THE CHURCH AND THE HEALTH CARE CRISIS: TOWARD A STRATEGY FOR COMMUNITY PARTICIPATION

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INTRODUCTION

This dissertation purposes to suggest new strategies for church involvement in the health care field. The thesis is not that the church must begin to be involved, but that it must find new ways to express its mission in health. Religion and health have been associated throughout the history of mankind. "Medical treatment has always been associated with religious service and ceremony. Early priests were also physicians or medicine men, ministering to spirit, mind and body."[1] What is proposed is that the church now widen the scope of its involvement beyond "medical treatment" and its customary "ministering to spirit, mind and body." It is suggested that the primary shape of the new strategies is systemic, *i.e.*, the emphasis is on the involvement of the church as a corporate body rather than on the Christian and his individual efforts. Its ministry is to the structures of health care with the goal of fostering quality care and new patterns of delivery accessible to all persons.

Several exciting proposals for the delivery of health care are being tried. A mood of change is beginning to be felt among concerned citizens and health professionals

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[1]Clarence R. Rorem, "Hospitals," in *Encyclopaedia Britannica* (1962), XI, 791.

who are listening with their stethoscopes to the heart of America.

In 1969 President Nixon spoke at the release of the "Report on the Health of the Nation's Health System" and thus joined the previous two administrations in underscoring the critical nature of health care. What has appeared to be a "first" for his Republican administration is the result of a timely statement. The public now is recognizing what has been expected for sometime by health professionals, particularly those in public health, as well as the sensitive and enlightened physicians. As early as the 30's, difficulties were growing.[2] The storm was at hand in the late 50's and some were determined to take action. In 1962 the National Commission on Community Health Services was formed jointly by the American Public Health Association and the National Health Council to "cope effectively with new and changing hazards to health, reduce the waste of health service resources, and prepare for the health service demands of the future."[3] Now in the 70's the health care crisis appears to be one of the major issues in the political arena. It is increasingly the tabletalk of families. Tourists who drive through small towns in rural

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[2]Anne R. Somers, *Health Care in Transition* (Chicago: Hospital Research and Educational Trust, 1971), p. 75.

[3]National Commission on Community Health Services, *Health Is a Community Affair* (Cambridge: Harvard University Press, 1966), p. ix.

America may see signs draped across the highways "Doctor Wanted." In various ethnic ghettos families experience the death of loved ones because they cannot locate a physician except across the sprawling city in the white, suburban areas. When serious injury or illness strikes, the spiralling cost of the care often places a person or family in heavy debt. Deprived persons who are unable to surrender an insurance card discover in an emergency that their loved one is carted to an overcrowded public facility. If they complain, they are judged by some as desiring "accommodations beyond [their] means."[4] Through news media and conversations the mounting problems in the health care system of this nation are encountered. There is a crisis. Some have chosen to refer to it as a revolution, and most observers agree that the crest has not arrived. President Nixon's label of a "massive crisis" served to underscore a growing national awareness. Sensing the necessity for some theological input as the health system is being altered, the research for this work was begun.

In order to develop some new strategies for the church's involvement that fulfill the purpose of the church the nature of the health care problem will be studied and described within certain limitations. A key element in the

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[4]William D. Sharpe, M.D., *Medicine and the Ministry* (New York: Appleton-Century, 1966), p. 11.

analysis of the present health care situation is to distinguish between problems and issues. To make such a distinction is to move beyond the problem level by a process of redefinition. Problems are those aspects of a situation which are observable to concerned persons, some even to the untrained eye of lay persons. But when the situation is redefined, and the basic concepts are viewed from a different perspective, then one begins to raise issues. In the case of health care one can look at medical practice by physicians as the diagnosis and treatment of illness. But suppose the focus were changed from an emphasis on illness to an effort to maintain health. Then the work of a physician can be seen not as an attempt to help sick people get well, but as an attempt to keep healthy people from getting sick. From that angle different matters concern those who wish to be involved in health. These emergent issues will be considered.

At present, the church appears to be part of the problem since its focus is purely on a ministry to individuals and is not making any effort to help restructure the delivery of health care for greater accessibility and quality. A theology of the church is proposed to show why the church ought to be a facilitating, catalyzing presence in the health field, why it is obligated to be involved, and why the church as a corporate body must be present. A sociological analysis is then undertaken to justify the

institutional interface of church and health systems. The systemic approach enables the church to view the problem from an organizational perspective as well as to consider the needs of the persons within the systems of health care. When such analysis has been made, the church is in a position to initiate action to influence the situation.

To discuss the health field fully is not possible. One of the great needs in any community is to have a planning association that is responsible for initiating a comprehensive health care program and to coordinate all efforts to carry it out. But this dissertation is limited to a consideration of personal health care. Mental and public or environmental health, the participation by government agencies in health care, and financing mechanisms have not been forgotten, but are not considered. These important dimensions deserve study from the perspective of the church and it is hoped that such will be forthcoming.

Finally, the choice of the work by Katz and Kahn[5] resulted from a semester of research in systems analysis. Since a systems approach to the problems and issues in health care is needed in order to bring about change, this fundamental text by the two University of Michigan social psychologists was selected. Their work allows one to view

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[5]Daniel Katz and Robert L. Kahn, *The Social Psychology of Organizations* (New York: Wiley, 1966).

both the larger and smaller questions of society, namely institutional interaction and the dynamics of the individuals. Drawing upon and modifying the pioneering works of Kurt Lewin, Talcott Parsons, Floyd Allport, and von Bertallanfy, they articulate a theory of open systems and argue persuasively that innovation must be cognizant of the nature of social organizations and the constant interface of systems.

CHAPTER I

NATURE OF THE PROBLEM AND EMERGENT ISSUES

1. THE CRISIS IN THE HEALTH SYSTEM

The apparent and commonly discussed elements of the crisis in health care are the problems of manpower, finance, facilities, and decreasing quality. What is the nature of these elements? How do these matters contribute to the crisis? In the case of manpower, the evident errors are the shortage and the distribution. With little effort the error of discrimination racially and sexually also appears. What are the dimensions in these elements?

The shortage might be viewed from a ratio of physicians to population. In the early part of this century the reform in medical education, largely as a result of the Flexner Report,[1] pruned the supply and enhanced the profession. By 1930 there were 125 doctors per 100,000 population, and following the Second World War concerted efforts increased the ratio to 133 by the late 50's.[2] The two sets

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[1]Abraham Flexner, *Medical Education in the United States and Canada* (New York: Carnegie Foundation, 1910). He conducted research in 1910 which led to the elimination of inadequate proprietary medical schools by public law.

[2]These figures include the total number of physicians in non-federal capacities so that retired and part-time practitioners and doctors in administrative posts and

of figures are set forth here to serve as bench marks for the highest and lowest levels. The prediction for 1975 is 128 per 100,000. The forecast indicates a continuing shortage which is worse than one realizes because of elements not readily apparent.

There are three other critical elements which drastically alter the statistics cited above. They are (1) the increasing number of medical school graduates who are not entering practice for patient care, (2) the poor distribution of those who practice, and (3) the percentage of foreign-trained nationals who staff many of the university and community hospitals. Dr. Rashi Fein reported that

> in three decades, 1931-1963, the total physician population rose, but both the number and the ratio of potential family physicians--pediatricians, internists, and general practitioners and part-time specialists in private practice--fell.[3]

Another eminent authority on health matters, Anne R. Somers, declared that in 1950 there were 76 general practitioners per 100,000 people whereas in 1965 the number had decreased to 50 per 100,000.[4] Specialization and other fields are

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research are included. Likewise, specialists are included even though they limit their practice to a particular segment of the sick. Therefore, there is some question as to the validity of the figures. The actual number of physicians who care for patients is much smaller.

[3]Rashi Fein, *The Doctor Shortage* (Washington: Brookings Institution, 1967), p. 71.

[4]Anne R. Somers, *Health Care in Transition* (Chicago: Hospital Research and Educational Trust, 1971), p. 75.

taking a toll on the physicians available to the public for family care or general practice.

The distribution situation is equally distressing. It is directly related to the shortage of physicians. If a person is well-to-do, white, and living in a suburban area, he will have more doctors to choose from than his hypothetical opposite who will be black, poor, and "locked" in his rural patch or urban ghetto. "While Los Angeles had 127 physicians per 100,000 population, in its southeast district of Watts, there were 38."[5] The distribution is uneven for regions as well as cities. New York State was able to offer 199 medical doctors and doctors of osteopathy per 100,000 and Mississippi had to suffer under a ratio of 69 per 100,000.[6] A person hopes that he will not be in a location which requires that he travel twenty or thirty miles over dirt roads to the nearest trade center and a physician. Yet, he may live in a section of Chicago where five physicians serve 50,000 persons and where health facilities are as distant as the trade center mentioned above although the actual distance is only eight or ten miles. Until a mechanism of distribution is produced, an increase in the supply will not alleviate the grave deficiencies in some areas which exist, seemingly, on the basis of the

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[5]Citizens Board of Inquiry Into Health Services for Americans, *Heal Your Self* (1970), p.18.

[6]Somers, *op. cit.*

desire to be near sophisticated technology and the opportunity to enrich one's self.

The presence of foreign-trained nationals raises a serious moral question, as well as suggests that the recital of statistics does not tell all. "Nearly 20 percent of all physicians who entered practice in 1959 received their medical education in a foreign country."[7] By 1969 the figure of 20 percent had increased to 30 percent. One might suggest that it would be no problem in an ethical sense if all the foreign doctors returned to their own countries, but unfortunately this is not the case. The figures just mentioned speak of those who completed internship and possibly a residency and entered practice in this country. They are lost to their countries who need them. The point, however, is that these foreign-trained physicians enable the United States to claim a higher ratio of physicians-to-population than would otherwise be possible, and the underlying concern then is the quality of the medical education of those trained in other countries. The national crisis is being solved in part by other nations, to their detriment and possibly to ours.

The "doctor drought" is a problem, but physicians now make up only 10 percent of the 3,400,000 health

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[7]Herman M. and Anne R. Somers, *Doctors, Patients, and Health Insurance* (Washington: Brookings Institution, 1961), p. 108.

professionals.[8] Doctors are not the only concern. There are severe shortages in other areas, too. The projected need for nurses for 1975 is 850,000. In 1962 550,000 nurses were available and 117,000 of these were part-time.[9] This projection from the Surgeon General was disheartening because he saw the need by 1969 to be graduating 100,000 nurses annually to reach the level of need and yet only a net gain of 10,000 was being realized each year. In the area of the allied health professionals the picture is no better. There the need calls for a half million persons to fill various positions, *e.g.*, laboratory technicians, inhalation therapists, and x-ray technicians. There will be a need for over 50,000 dentists.

In the face of the "massive crisis" due in part to the manpower shortage, there is little comfort in the increased technology and the development of new positions to alleviate the professional shortage, such as physician's assistants (some are called medex, mini-doctors, or maxi-nurses), the Armed Forces medics who by examination become registered nurses, computers for diagnosis and record

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[8]William L. Kissick, M.D., "Health Policy Directions for the 1970's," *New England Journal of Medicine*, CCLXXXII (June 11, 1970), 1343-54.

[9]National Commission on Community Health Services, *Health Is a Community Affair* (Cambridge: Harvard University Press, 1966), p. 81.

keeping, and closed-circuit TV for remote analysis of symptoms. Public demand is moving faster than the new technologies are being adapted to health care. Some persons have suggested a massive effort to train more doctors. In that connection Senator Charles Percy commented that 75 medical schools could have been developed if funds allocated for the ABM in the last year had been designated for the health manpower shortage.[10] Instead, the problem remains, and projections are disheartening because not enough is being done to develop more health professionals and distribute them equitably.

Certain statistics cause one to conclude that discrimination exists in the selection and training of health professionals. The number of blacks in the nursing and medical categories is quite small. The percentage is about two or three black physicians whereas the blacks comprise about 10 percent of the population. There are now 2.75 percent blacks in medical schools with a total enrollment of 37,756, which is only a .54 percent increase over the 1969-1970 first year enrollment. The nation cannot expect a better percentage until there are better educational opportunities or alternative routes for the black person to enter medical training. Even if the scholastic picture

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[10]"What Dimensions to the Shortage of Doctors?" *Perspective*, VI, 4 (1970), pp. 19-27.

changes in some direction, the financial squeeze in medical schools (which is worsening) will eliminate the minorities unless alternative financing is developed. The brunt of any direct or indirect racial discrimination which applies to American Indians, Mexican-Americans or Chicanos, and Puerto Ricans, as well as the Orientals, is borne by the consumers of health care in the ethnic areas. In each ethnic area there are unique life styles and values, folkways, and mores that enter the health picture. The lack of minority professionals in the training of doctors results in the failure of these life styles to be included in the medical education. Therefore, ghetto residents do not get the benefit of physicians who understand the ethnic life styles which would enhance the healing process.[11]

Sexual discrimination is even worse. Women comprise only 7 percent of the total number of doctors, and in the population they are 51 percent of the total. These practices of discrimination on the basis of racial or ethnic origins and sex indicate something of the nature of the medical profession. The manpower problems will not be solved until that <u>something</u> is understood. It will be considered later among "underlying causes" as professional dominance.

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[11]Citizens Board..., *op. cit.*, p. 20.

As soon as a person examines the financial picture he realizes that the cost of medical care has spiralled to such an extent that he cannot afford to be sick. In fact, the forecasts of health care costs in the next five years makes one feel as if he ought to hurry up and get sick now. Probably as important an element as any at this time is the legislation on national health insurance before the Congress of the United States, but the many mechanisms for financing the health system, including the sizeable and varied governmental efforts, though very important are very technical.

An example of the burden of the costs comes from Senator Abraham Ribicoff.

> About two years ago the wife of a forty-three-year-old house painter in Alabama was hospitalized for cancer of the cervix and colon while pregnant with the couple's fifth child. Over an eighteen-month period she had several major operations, round-the-clock nurses, and heavy dosages of expensive drugs, but she died. Her husband was left with a $30,000 medical bill, of which only $9,000 was covered by insurance.[12]

Lifetime debts are one result. But for many, many others even the price of some capsules is too much. Or the doctor's fees may even seem an insurmountable obstacle.

> One mother despaired of getting medical help for her daughter who was suffering severe stomach cramps: "If only I had money to take her to the doctor again, I would. But I can't take her to the doctor unless I can pay cash before he sees her."
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> A VISTA volunteer doctor in eastern Arkansas recounted

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[12]Abraham Ribicoff, "The 'Healthiest Nation' Myth," *Saturday Review*, LIII, 34 (August 22, 1970), 18-20.

> the following experience: "At one neighborhood action council meeting, I asked all those who in a time of need had not gone to a doctor because they couldn't afford it, to stand up. Fifty out of the 55 at the meeting stood up....[13]

In the volume *Heal Your Self* from which the above two accounts were taken are numerous other first-hand anecdotes from the national survey conducted by the Citizens Board of Inquiry into Health Services for Americans which was chaired by Lester Breslow, M.D., of the School of Medicine at UCLA. Is there some therapeutic advantage to the exchange of money for services? Some doctors think so.[14] If so, what is to be provided for those who are not able to afford care? Does a lack of money imply that health is not a basic right of all persons regardless of race, creed, color, as the United Nations declared twenty-five years ago?

There are persons who cannot afford health care. Some may not be able to afford it but find ways to pay for it. Others, who can afford it, paid a total of $37 billion for health care in America in 1965. In 1970 the costs had risen out of proportion to the cost of living and skyrocketed to $68 billion. Prognosticators speak of a $100 billion figure by 1975 and $200 billion in the early 1980's.[15] Americans spend more money on health care than

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[13]Citizens Board..., *op. cit.*, pp. 1-2.

[14]*Ibid.*, p. 16.

[15]Ribicoff, *op. cit.*, p. 19.

any other nation and get poorer care (see below on decreasing care). Six and seven-tenths percent of the Gross National Product was spent for health and medical care in 1969. The figure was 7 percent in 1970 and is rising. Yet, the countries with better care, *e.g.*, Sweden, spend less than 1 percent of their GNP. Another way to analyze the cost spiral is to see that hospital charges doubled between 1956 and 1966. They jumped another 50 percent between 1966 and 1969. Citizens hear complaints of the ineffectiveness of federally-sponsored financial help for health care, *i.e.*, Medicare and Medicaid, and research does indicate a correlation between the enactment of the legislation and the spiralling costs. Reliable sources are placing considerable burden on <u>some</u> physicians who abused the situation and enriched themselves at the expense of the taxpayers and the poor. It would be more accurate to <u>criticize</u> the process of lawmaking and the lack of cost control in the program.[16] Some persons would suggest that the solution lies in more money for the health industry.[17] However, neither federal schemes or the third parties such as Blue Cross-Blue Shield or the independent companies have

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[16] *cf.* Edmund K. Faltermayer, "Better Care at Less Cost Without Miracles," in Fortune, *Our Ailing Medical System* (New York: Harper & Row, 1969), p. 35.

[17] *Ibid.*

really helped the consumer.[18] Just as more manpower alone will not change the situation unless there are systemic changes so one concludes that more money will not eliminate the problem. In fact, the higher the costs the worse is the situation for the consumer. His debts are just bigger. The structure must be changed.

Bricks and mortar are just as difficult to comprehend as manpower or costs. After the Depression and the Second World War medical facilities were in great need of repair and expansion. The Hill-Burton Act has supplied federal funding for hospitals. As a result, the number of beds or the capacity of the primary health facilities has been increased.

> Through fiscal 1969, the Hill-Burton program approved construction or modernization of 442,965 hospital inpatient beds and 2,888 other facilities. Of the $11.2 billion, the total cost of the projects, the federal share was $3.4 billion.[19]

Some of the non-federal costs may have been met through state or municipal funds, but even then one may say that the total costs were paid for by consumers. Taxpayer and/or consumer money is used but where is the social responsibility and the fiscal accountability to the public? When the facilities-and-equipment hassle has been studied, the evidence points to the need for consumer participation. As

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[18] *Ibid.*, pp. 15, 33.

[19] Citizens Board.... *op. cit.*, p. 28.

the repair and expansion boom in the health industry progressed, the need for comprehensive planning arose. Public Law 89-749, the Comprehensive Health Planning and Public Health Amendments of 1966, provided for consumer participation and comprehensive planning. There were features in the law to induce hospitals to plan in concert with other units of the community. But a Hospital Council official indicated in a discussion that the law is not very effective. Why?

There is a struggle for funding, and hospital boards who plan to enlarge their facilities and get federal funds are supposed to be screened by a local comprehensive health planning association which is comprised of 51 percent consumers and 49 percent providers, but there are loopholes. In some cases, the consumers are the well-to-do, respectable citizens of the community who are on the boards of trustees of local hospitals, others are managers of pharmaceutical houses, etc. The answer to the why partly lies in the lack of consumer organization. Another part of the answer resides in the fact that society-at-large continues to believe that all matters concerning the care of the sick should be controlled by the experts. However, though the consumer may not know the appropriate treatment for the specific disease, he does know whether or not he has easy access to the facility. He knows, also, that a facility which is equipped with expensive technical

instruments and machines but stands idle on weekends is not being properly utilized. To ask the "why" is to begin to see that one of the underlying causes of such problems is professional dominance which will be discussed later.

In the above discussion the question of accountability was raised. To speak of accountability raises the matter of the quality of service given by those in the health field. Someone needs to be responsible for the 75,000 babies who die at birth in the United States each year. The providers are not solely liable. One is aware of a societal responsibility when he hears the statistics that (1) nonwhite American babies die at a rate nearly double that of white American babies; (2) American mothers die in childbirth at a rate exceeding that of 11 other countries; and (3) nonwhite American mothers die in childbirth at a rate four times the rate for white American mothers.[20] As one sees these statistics and considers that infant mortality dropped from 8th place in 1954 to 17th in 1969 among the nations of the world, he wonders about the quality of care. Certainly the effectiveness of health care is in question. This is particularly true when it is known that American males have a shorter life expectancy than the males of 19 other industrial countries and that the American females life-expectancy rate is seventeenth. How

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[20] *Ibid.*, p. 15.

can a nation which spends 7 percent of its GNP fare so badly? Is it manpower, money, facilities? Most serious students of the health industry have shown that more money or manpower or facilities will not enhance the health of the nation until there are basic structural changes. To grasp the conclusion of these serious students the underlying causes need some delineation.

A consideration of the underlying causes calls for an initial examination of professional dominance which has been hinted at earlier. If one is sick and hospitalized, he soon learns the "pecking order." If he wants a medication, he must have a prescription signed by a physician. One of the causes suggested for the poor management of hospitals is the hiatus between the administrator and the chief of staff. The basic loyalty of the physician is to his profession rather than to the health care facility. Seemingly, all persons and things exist for the physician. This matter of professional dominance makes the medical professional a peculiar creature.

How did such a phenomenon develop? Some persons point to the medical school and the influence of his training in the shaping of his practice. Other persons suggest that the physicians in the process of practice develop the medical mystique. There is solid ground for such a position when the impact of peers and group values, norms and roles are considered. But there are two specific factors which

cut across the physician's education and his peer involvement: medical responsibility and clinical experience. The responsibility of the doctor for the diagnosis and treatment of the patient is fundamental. It is drummed into him at medical school. Responsibility is the implicit element in the doctor's development of a circle of colleagues who make referrals to him. The factor of clinical experience, which means that there is no substitute for the "real thing," is tied into medical responsibility. In his schooling the young doctor-to-be who wants to gain skill discovers that more emphasis is placed on practical applications than on theoretical knowledge. If he does not handle his cases well, he will not be entrusted with increasingly difficult ones. Yet, if he is not given more and more cases, he will not be able to develop his skill. He is responsible and he must make the diagnosis and treatment that assure the health of the patient. Necessarily, there are risks. The doctor must believe in himself and he needs sufficient cases to build that self-trust. Increasingly, he sees himself as autonomous, self-directing in his work. Since he is responsible, his therapeutic plan must not be interrupted.

This development of the professional dominance is crystallized by the organization of those persons who practice medicine. The medical society protects the physician and enables him to practice without interruption by

securing the legalized monopoly of the health services.

> The leaders of an occupation persuade leaders of society that its members possess some technical competence so special and of such importance that the public should be prevented from using any other occupation with the same domain but assertedly less competence or integrity.[21]

So "the physician [becomes] the ultimate expert on what is health and what illness and how to attain the former and cure the latter."[22] Is it any wonder then that the physician is more devoted to his profession than to the public good or that he sees the two as the same? He is dependent on his professional organization. He sees the public good and the enhancement of the medical society as the same since the professional body enables him to practice medicine as he believes it must be practiced (medical responsibility) and that is for the public good (people get treated).

Of course, the distressing side of professional dominance militates against the patient's health via a poorly functioning health system which seemingly cannot be reorganized. The patient is depersonalized in the system. He is an object in the hospital which is a workshop run for the benefit of the practitioners. If the doctor makes too

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[21]Eliot Friedson, *Professional Dominance* (New York: Atherton Press, 1970), p. 122.

[22]*Ibid.*, p. 147.

many poor diagnoses, he will not be called upon by certain of his colleagues.[23] He will move to a circle that fits his ability, and all the time the patient suffers from the poor treatment because of the lack of an effective control or evaluation of professional skills. To counter negative criticism of the lack of external review, medical practitioners speak of the client's freedom of choice. "If you don't believe in me, then go to another doctor." For many people, there is no other choice. The distribution and shortage of physicians insure this. Other persons experience that the use of fees, appointments, and brief consultations imply that this doctor is very busy and does not have time to justify his expertise. Patients put themselves into the hands of the physician and impute to him competence.

The principle of medical responsibility with its monopoly on those resources necessary for treatment, *e.g.*, drugs, admission to hospitals, etc., also causes poor functioning in the health facilities. All treatment must

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[23]Dan Cordtz, "Change Begins in the Doctor's Office," in Fortune, *op. cit.*, p. 55. The author reports that Dr. Osler L. Peterson and his team conducted a survey of doctors in 1956 in North Carolina and "concluded that more than 60 percent of the therapy was below acceptable standards. In 1962 and 1964 a medical team from Columbia University School of Public Health and Administrative Medicine studied the care of a random sample of patients in ninety-eight hospitals in the New York City area. Forty-three percent of the treatment was rated less than 'good'; 23 percent was labeled 'poor.'"

be specified. Only physicians by licensure are permitted to perform certain tasks. In an atmosphere of autocratic authority, the flow of information is basically one-way, downward from doctor to nurse to other allied health professionals. Morale then is poor and patient care suffers because of the professional dominance which has kept the nurses and other workers as second-class people horribly underpaid.

Because of professional dominance the possibility of change in the health services seems very slim. When one considers the consistent and persistent fight of the American Medical Association against every innovative measure for health sponsored by the government as the representative of the people in the past fifty years,[24] the prospects for future innovations are tragically stark. But, as a therapist knows in his counseling of persons, no one has any more power over another than the amount a person is willing to grant unless the structure within which one must live limits the powers of the person. The meaning of the statement in the context of this discussion refers to the public who have been willing to yield to the physician the ground on which to develop professional dominance. Why? What is is the nature of the cultural totem and taboo (totem: he's

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[24] *cf.* Richard Harris, *A Sacred Trust* (Baltimore: Penguin, 1966).

good; taboo: don't challenge the doctor)? In primal societies witch doctors and shamans possess considerable influence in their societies or tribes. When one looks at the biblical account of Joseph and Daniel and their ability to interpret dreams and the favor granted them by the royal house, the thought arises that another example exists for a universal elevation of the officeholder who is capable of dealing with the mysterious elements of life. It seems likely that societies are going to make totems of those who assist us in the midst of trauma. A doctor or dream analyst becomes privy to the council of the leader of a nation because in an hour of seeming death the physician was the channel through which the leader became a participant again in that which is known: namely, life itself; and escaped that which is unknown, the perceived idea of an existence after death. So it is not surprising that doctors in our society are called upon and imputed competence in vast areas beyond their technical skill or art. It is not surprising that they are granted the ground on which to build the myth of their sole right to hold the resources of health.

The increasing technological advances, similarly, have had their impact on the health field and are an underlying cause of many of the problems. No longer is a doctor able to carry the tools of his trade in a little black bag. Medical gadgetry has forced him to locate near hospitals or

to enter into a partnership with a few doctors who are able to afford to equip their clinic with the costly developments of medical technology. Disposable syringes and gowns may facilitate the handling of more patients and save labor and prevent disease, but they also hike the cost of care. The everchanging pharmaceutical scene tends to force the physician to rely on the drug detail men, who in a sense become the link between research and the practitioner.[25] Hospitals, medical equipment corporations, drug companies, and doctors are fast weaving a huge web in conjunction with insurance companies for a vast medical-industrial complex that soon will be the largest employer in this nation.[26]

Certainly, the rising expectations of the public for better health care, which is partially fostered by Medical Center, The Interns, Marcus Welby, M.D., and other TV programs, as well as the expanding coverage of printed media apropos the health care crisis and technological developments, increase the problems. More people expect more care. More people want to be in the hospitals. More people are asking for certain treatments. Why are they not able to be on a kidney dialysis machine? Why should

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[25]Ronald G. Havelock, *et al.*, *Planning for Innovation* (Ann Arbor: Institute for Social Research, University of Michigan, 1971), p. 7.3.

[26]*cf.* Harold B. Meyers, "The Medical-Industrial Complex" in Fortune, *op. cit.*, pp. 65-74.

treatment of disease be preserved for only those who can afford it? Is not health a basic human right? The pressure builds. More facilities are needed. More manpower is needed. And costs rise. Add to the mushrooming expectations of a public which is also increasing in numbers the increased debate in Congress and the discussion at lunchroom counters about the "crisis in health care" and the result is more fuel added to the fire.

The fire that is now burning is the redefinition of medicine-health (it is a problem to know what to say!). In the process of redefinition issues begin to emerge. The problems are seen as the symptoms of these deeper issues. And the problems then appear as minor difficulties compared with the major difficulty of the search for solutions to the emergent issues. These issues are, *e.g.*, (1) shall the focus be on the diagnosis and treatment of disease or shall it be the maintenance of health? (2) who shall have access to the comprehensive health systems (environmental and personal) for education, prevention, early disease-detection, diagnosis and treatment, and rehabilitation? (3) who shall control the health structures or be decision-makers apropos the patterns of health delivery? and (4) what mechanisms of evaluation for health professionals shall be instituted?

To raise the question of health maintenance may seem trivial, and yet, it would require the physicians and the patients to reorient the practice of medicine. Health

education would be given a much higher priority than it has been given in the past. Patients would have to take much more responsibility for their health than they have done up to now. They would be required, for instance, to keep a "shot" record and be present periodically for the tests and innoculations which are necessary for early disease detection and prevention, although computers could be used to keep records and mail notices. Physicians would be required to change their financial structure from fee-for-service to a capitation basis. The thrust of their profession would be on the continuing efforts to maintain personal health rather than the episodic treatment of some ailment or disease. And both patient and physician would be part of a comprehensive health system which carried responsibility for environmental and personal health. The significant change in direction for providers and consumers would demand much from each group. It is not a trivial matter to change the focus from illness to health.

The matter of who shall receive health care poses a threat to some. The World Health Organization spoke of health for all twenty-five years ago. Today the nation that spends the most for an "illness oriented system" is just beginning to say that health is a basic human right. In some circles such a statement is acceptable; in others it is not. When one considers that the low-income segments of the population in the United States suffer the most

from the present system which is not only illness-oriented but also oriented to those who can pay (unless one is willing to be a guinea pig in a teaching hospital), it becomes clear that all Americans need accessibility to quality care. Over two billion dollars are lost in wages because of ill health. If health care were made available to those who earn $3000 and under per annum and on the same basis of quality as those who earn $10,000 and over, the loss in wages would be only $.8 billion. Stated another way, such care would mean that the 96 million (or 50 percent of the population) who suffered chronic ill health in 1967 would have had opportunity for treatment. There is no doubt that when national legislation first acknowledges that all Americans have the basic right to health the cost will be great because initially many will utilize the opportunity to treat that which they had not been able to afford before. Yet, there are those who insist that if one cannot afford to pay for health care, he should have to go without. Who is willing to decide which person will be forced to die because he cannot afford health care? Ought any one be able to make such a decision? Or does not this nation, every citizen, make such a decision daily as long as national legislation is not enacted to provide comprehensive health care to all persons? Accessibility on the basis of right is a sticky issue, too.

Probably, the question of control raises more noise

than any other issue, unless it is that of evaluation. The medical profession has legally controlled the total health system in this nation and they have expended billions and billions of dollars to defeat any program which they perceived as invading their domain. But slowly the issue of community participation in the process of decision-making has been rising. For the most part, consumer involvement has not been effective, but one imagines that as costs spiral the pain in the pocketbook will motivate citizen-groups to organize and to demand seats on the governing bodies of hospitals. The politicians will be pressured to enact legislation with more teeth that insures consumer participation at the decision-making level. Conceivably, local communities will experience the formation of health-care corporations which have been organized by the disenfranchised consumers of the past who will in the future make contractual arrangements with the various providers of comprehensive health services. In any case, the concern for community participation is not a demand for power in decisions regarding treatment. The focus is on the planning and management of the delivery systems. Community participation is an issue at these points, and the people are capable of sharing in the process of deciding where facilities are to be located and how they are to be structured and operated. But such a desire to control health-care delivery raises a red flag among the health professionals.

One wonders how it will be resolved among physicians who have ruled their domain for so long with an iron-hand and a citizenry increasingly aroused against exhorbitant depersonalized, poor care.

The issue of evaluation, however, may be even more touchy than that of control, although they are closely related. The long-standing tradition has been peer review. However, as Friedson points out in his book, unless there is serious error, peer review in effect becomes review by that circle of colleagues with whom one works. If a physician is observed by his colleagues to make too many mistakes, he is not called upon by his peers nor are referrals made to him. He then gravitates to the group of doctors who will accept him. Furthermore, when a society, *i.e.*, a professional group, realizes the gain of having competence imputed by the client, considerable attention will be given to a public condemnation or reprimand. Thus, peer review has certain disadvantages. At the same time, the practice of medicine is both an art and a scientific skill. The layman is limited in his ability to evaluate the quality of the care. So the heart of the issue of evaluation probably is the desire for more effective means of reviewing the physician's capabilities by his peers than now exists. Would a periodic sampling of a physician's records be more effective? The hallowed tradition of the doctor's individual responsibility for his patient is in jeopardy then.

Would the practitioner be more responsive to a health care corporation who contracted for his services on a capitation basis with a bonus annually paid from the reserve which was not exhausted by the over-use of expensive facilities and equipment and which required excellent preventive, educational, and screening techniques? It is doubtful as long as the precious fee-for-service system is guarded by the American Medical Association. However, the public wants quality care, and malpractice suits are increasing at such a rate that a 110 percent raise in insurance costs occurred in California in 1969. They had been raised 95 percent the year before.[27] Other states are experiencing similar developments because more doctors are being sued and the settlements are mounting rapidly.[28] The public wants a system that assures proper evaluation, and the physicians want an instrument that enables them to perform their art and skill. The answer is not available but probably it will be different than what we now know.

These issues then arise as one seeks to redefine the elements of health care. The problems are serious, and the development of a workable financial mechanism may prove to be the easiest one to solve even though it is

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[27]Anne R. Somers, *op. cit.*, p. 11.

[28]*Ibid.*, p. 24. "Only about 30 percent of the money paid out by insurance companies in malpractice awards goes to the patient; the rest goes to the lawyers."

seemingly causing the most difficulty now as Congress considers several proposals for national health legislation. Yet, the problems will not be solved until some of the underlying causes (professional dominance, totems and taboos, and technology) are understood and demythologized. In the total process, the issues will be dealt with and through dialogue between providers and consumers practitioners may lose their mystique, new patterns of health care may be developed, and the phrase "community participation" may become a reality. However, these changes will occur only if a concerted effort is made to resolve the problems at the level of basic issues and causes. Fortunately, there is a growing cadre of concerned professionals and citizens who are actively at work on the cutting edge. The primary concern is the place of the church in this dialogue. What is the church doing in the midst of this crisis?

2. THE CHURCH'S APPROACHES TO HEALTH IN HISTORICAL PERSPECTIVE

At first glance one may question the inclusion of the church in the problems of the health care crisis. The church must be included as long as it continues to respond to the situation in the 1970's only through church-related hospitals and the hospital chaplaincy, as well as to appeal to physicians to allow the clergy to be "members of the team" in the sick room and to encourage the health

professionals to perceive themselves as individual Christians called by God to their profession. As such it is really only the "chaplain of the *status quo*. To be part of the *status quo* is to be part of those serious problems that demand change and issues that must be resolved. Of course, the word only was stressed in the above sentence, and the implication of the italics is crucial for an understanding of the problematic nature of the church's approaches. Certainly, there is validity and necessity for hospital chaplains and for clergy to be partners on the healing scene but not a partnership on the basis of appeal. Such work, however, is individualistic only and is not cognizant of the systemic nature of existence and the structural changes that must occur. Furthermore, if church-related hospitals today were operating on the frontier of health care as their American predecessors of the 19th century were, they would be dealing with a distinct lack in society. Those first church-related hospitals in this country provided health care for the poor. Likewise, if there were nurses, physicians, and other health professionals who were part of a strong, organized vanguard within their professional organizations, consciously and consistently working for structural changes in the patterns of health care delivery, then the church would not need to be included as a component of the problem. Each of these facets are part of the problem because the church has fostered and/or permitted an

individualistic style of ministry in the chaplaincy and among professionals and church hospitals.

How did the church espouse the individualistic style? Is it not primarily due to the value system of the ones who settled the United States and the rural setting of the wide expanses of the nation which fostered such a perspective? This nation has seemed to honor the idea of "rugged individualism," the Horatio Alger possibility, and practiced a foreign policy of isolationism. The nation has experienced considerable change with the Second World War and the shift of the population to urban centers. The last decade of tensions within the churches seems to have raised questions about priorities in the work of the church, the saving of souls *viz a viz* the changing of structures. One wonders, then, if the impact of a nation's experiences since the "forties" has altered the concerns of the church, or modified its Scripture and tradition as compared with the first hundred years or so of this nation's history. An answer to the question does not come easily but one is conscious of the influence of Pietism on the history of the church in this country. Gibson Winter wrote

> "Pietism" describes the Church when it is preoccupied with private values--such as emotional balance, the nurture of the children and the development of personal moral virtues... "Servanthood" describes the Church when it sees its responsibility as ministering to the total life of the "metropolis"; preparing the laity to witness, within the structures of society, to the

destiny of the world in the final purpose of God.[29] Pietism is not unique to the United States. It is characteristic of, and developed in, Lutheran Germany as "a breach with these tendencies," *viz.*, the dogmatizing of the Christian life, the passivity of the laity, and the elevation of the clergy.[30] But the thrust of Winter's statement is to portray the "-ism" of the development and the distortion. It is the over-emphasis on the individual that disturbs. The posture of individualism has kept the church from grasping the significance of a pastoral ministry to structures called for by Robert Bonthius.[31]

One way to illustrate the pietistic influence, the exaggerated or exclusive emphasis on the private, is to survey the development of clinical pastoral training. This is valuable also because it shows the orientation of hospital chaplains and the need to provide a complementary

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[29]Colin W. Williams, *Where in the World* (New York: National Council of the Churches of Christ, 1963), p. 77.

[30]Williston Walker, *A History of the Christian Church* (New York: Charles Scribner's Sons, 1918), p. 496.

[31]Robert H. Bonthius, "Pastoral Care for Structures --As Well as Persons," *Pastoral Psychology*, XVIII, 174 (May 1967), 10-19, cited in Harvey Seifert and Howard J. Clinebell, Jr., *Personal Growth and Social Change* (Philadelphia: Westminster Press, 1969), p. 13. Gerald G. Walcutt, chaplain supervisor at the California Institution for Women, Frontera, California, indicates to his students the need to be sensitive to the institution and ways to respond to it as well as to the individual needs of staff and residents.

ministry in the health field. A preoccupation with private values mentioned by Winter seems to have been the *a priori* attitudes of Cabot and Boisen, two of the founding fathers of the clinical pastoral training movement.[32] Another progenitor, Keller, was committed to social engineering, but his concern was not maintained in the movement. The medical model dominated. In his monograph tracing the history of the clinical pastoral education movement, Thornton said

> The use of clinical training to equip ministers for social engineering was the first but it has not been the main task of clinical pastoral education during the last four decades. The mainstream of the clinical training movement flowed into the channel of individual healing.[33]

The influence of Boisen, Cabot, Dunbar, and Guilles cannot be overlooked, particularly Cabot and Dunbar, both physicians. Boisen saw the movement as seeking "to call attention back to the central task of the Church, that of 'saving souls,'..." With this perspective he stands in the long and splendored line of *curatores animarum*. He always will be remembered for his desire that in addition to the printed documents the living, human document be studied by theological students. He first met Cabot in the Emmanuel Movement in Boston and both wanted to enable ministers to be equipped to "help people in trouble." Both men, however,

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[32]Edward E. Thornton, *Professional Education for Ministry* (Nashville: Abingdon Press, 1970), p. 40.

[33]*Ibid.*, p. 45.

saw troubles as basically personal and not systemic. Cabot even had difficulty accepting psychiatry because of its orientation toward illness as functional and centered in the unconscious. He believed in the organic cause of illness. Guilles, one of the early students of Boisen at Worcester State Hospital, was more oriented to the medical model and worked closely with Cabot.

Helen Flanders Dunbar's autocratic hand in the movement and her commitment to the professional medical model are evidenced in her achievement of winning the confidence of the medical profession.[34] She informed the physicians that the clergy needed their help "to do better what they must do anyway...and preventing the clergy from doing what they ought not."[35] When a person perceives the ideological underpinnings of physicians: solo-practice, the individual doctor and his patient, and the laissez-faire, fee-for-service basis of financing one's treatment of illness, then a physician's helping the clergy as urged by Dunbar means that a medical model would have been followed, a model that must be seriously questioned in these times. The result is that ministers who are clinically trained in the manner of physicians will adopt a "bottom of the cliff" ministry rather than building preventive

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[34] *Ibid.*, p. 84.

[35] *Ibid.*

fences at the top of the cliff.[36] The professionally-trained clergy are shaped by clinical pastoral training to respond to individual rather than structural problems. Until the last few years the emphasis has been on a "cure of souls" rather than the "pastoral care of structures."[37]

As one views the formation of the clinical pastoral training movement, the individualistic style of ministering at the bedside of the sick and the dying and of sharing with the bereaved and aged is the pattern of the church's response to sickness, especially by hospital chaplains. It also is the pattern of most parish ministers who see their response to the health field as one of calling on the sick. Probably the generalization may be made that most physicians and lay persons, also, perceive this response as the appropriate one. Such limited perceptions require that the church be included in the discussion of the problems in the health care crisis. This is particularly true when one grasps the potentiality of the church in the midst of social crisis. The church is one of the major institutions in society. The clergy is one of the major professions in society. Although there is much surmise about the demise

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[36]John Snyder, "Clergymen in a Preventive Mental Health Program." in Howard J. Clinebell, Jr. (ed.) *Community Mental Health* (Nashville: Abingdon Press, 1970), pp. 77f.

[37]Seifert and Clinebell, *op. cit.*

of the church, one still senses the possible efforts for good which she might wield. To see more clearly these possibilities the next chapter is devoted to a theological analysis of the church.

CHAPTER II

A THEOLOGICAL ANALYSIS OF THE CHURCH

A theological understanding of the mission of the church is essential if one is to establish some bases for criticizing the church's parochial approaches to the health care field. What justifies the thesis that additional and complementary approaches are to be strategized in the 70's? Why is the church to be involved in the "health ministry" on the basis of an interface between the two systems?

Of course, there are those persons who seemingly object to the church's involvement in society. They comprise a sizeable stream in the church which continues to opt for an emphasis on "the salvation of souls" and "a separation of the church from the world," even though they also continue to function six days each week at the lathe, behind the wheel of a truck or car, across a counter, before the jury, or on a girder twenty stories above the street. Therefore, an adumbration of the nature of the church seems crucial to provide a framework from which to consider the world-church interaction. Hopefully, it will then be clearer from a theological perspective why the church ought to be concerned in new ways of dealing with the health needs of our society, ways that complement existing patterns. This chapter, then, is divided into

three sections. The first section considers the nature of the church from the standpoint of the bases for its existence and states its purpose. The second section raises the question of how the church is to interact with the world or how its purpose is to be carried out. The third section draws from the previous sections and attempts to relate the church to the problems and issues of the health care field in a general way that looks forward to the specifics of the final chapter on strategy proposals.

1. THE NATURE OF THE CHURCH

In the process of trying to comprehend the nature of the church and to analyze the bases of its existence the thought was evoked that the church might be described as a polar configuration of people and God in a dynamic relationship. This seems at first to solve a dilemma: since a polar structure requires both elements to be held in tension, a choice cannot be made between the people or God. Both parts need scrutiny. The usual starting point is God. But is He properly the primary subject? No, because it is impossible for the Lord to be subject to anyone, which implies that the people are the true subjects and ought to be analyzed first.[1] But is it really possible to begin with

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[1] *cf.* H. Richard Niebuhr, *The Purpose of the Church and Its Ministry* (New York: Harper & Bros., 1956), p. 19. His first dynamic character of the church, *viz.*, the church

the people who comprise the church and to understand the basis of the church if one focuses on the church as a social reality? What is distinctive about a group of people? Is their uniqueness or identity known unless one is able to ascertain their origin? These questions suggest that the people are not the place to begin to assay the significance of the church because the peculiarity of their existence is not apparent until one grasps the dynamic of their faith. In that case, faith, which is a gift of God, implies that God must open the discussion of the basis of the church. Yet, the fact remains that both elements of the polarity are the essential bases of the nature of the church.

To see the church as a people whose existence is initiated by God and to lift up the element of faith as the peculiar dynamic of that relationship is accurate even though it is somewhat imprecise. The lack of precision is involved in the use of the term "God." Actually, the "Word of God" calls the church into existence. The Word begets faith and man's response is obedience to that Word. Emerito Nacpil, a rising Asian theologian with a brilliant mind and a passionate spirit, declares that "it is the Word of God and the Spirit of God who create community under

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is "the subjective pole of the objective role of God...It is the subject that apprehends its Object; that thinks the Other; worships and depends on It; imitates It perhaps; sometimes reflects on It; but is always distinct from its Object."

one Lord, and it is a community of faith and hope and love."[2] Thomas Oden captures the other side of the issue when he remarks that the "Church as the community [is] constituted by obedience to the Word."[3] God, it may be added, is the one who speaks the Word. God is the One who qualifies the term. And no play at words or splitting of hairs is intended. Rather, a crucial distinction is being made and that is the Christian understanding of the One who is other than the church though so very present. This specificity represents the recognition that the first step in the true knowledge of God begins with the knowledge of his hiddenness.[4] The Word is what men hear and "knowing his voice" they respond. "The 'Word of God' is God's creative activity as he relates himself to the world he has made."[5] The Word continues throughout the history of mankind as the initiator of those people who belong in a special way to God, of which there is both continuity and discontinuity between the people of the old covenant and the new people called Christians. The Word symbolizes language or the

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[2]Emerito C. Nacpil, *Mission and Change* (Manila: East Asia Christian Conference, 1968), p. 87.

[3]Thomas C. Oden, *Radical Obedience* (Philadelphia: Westminster Press, 1964), p. 85.

[4]Karl Barth, *Church Dogmatics* (Edinburgh: T. & T. Clark, 1957), II, 1, 183, in Gerhard von Rad, *Old Testament Theology* (New York: Harper & Row, 1965), II, 377.

[5]Robert McAfee Brown, *The Significance of the Church* (Philadelphia: Westminster Press, 1956), p. 32.

exchange between persons, and persons are the participants in history. The Word, then, specifies God's revelatory process through the medium of human existence or history. In the course of daily occurrences, which are interpreted and given meaning by faith--so the Christian affirms--so that one speaks then of events, God permits himself to be known. The thrust of the Biblical message is that God chooses to limit himself to being known through history.[6] The new people of God, as well as Israel before them, are not nature worshippers. They affirm his creative handiwork in nature as a result of knowing him as the Lord of history. He is confessed as Creator since the cosmos is the stage and backdrop on which and against which the drama of life is played. So the precise definition of the church is not "a people and God in a dynamic relationship." Rather, the church is a people claimed by and responsive to (a dynamic relationship) God's Word.

How has the Word been experienced in history? The place to begin is with Moses and the Exodus event. The event in Israel's history that enabled them to make sense of their heritage was the Exodus. Possibly the event

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[6]There is a considerable and profound stream within the Christian tradition that calls for a natural theology and does not want the realm of nature and its story to be lost. The position taken here is that the Christian perspective begins with God's mighty deeds among men and then moves to God's rule in nature and nature's place in the process of redemption.

evoked a desire to search the past and ponder the identity of their ancestors. The Old Testament sees the Exodus as the saving event that brought past and future into a significant now. From that present they looked back and noted the Abrahamic life style, a life of faith in obedience to God's Word. The same Word sent Moses back to the land from which he had fled. He was sent to deliver the people from bondage and to lead them to a land of their own. A generation was required to enable the people to be responsive to the Word and to move into the Promised Land, a land which they had not made but which was given them in order that they might be known as a special people in a special relationship to God.

As one traces the life of Israel back to Abraham and then forward to the time of Jesus of Nazareth, the Word is present and urging the people to respond. The Word comes as promise and the people are pictured as faithful and as unfaithful, *i.e.*, taking the risk and being obedient to the Word and discovering that they do have faith, or hardening their "hearts" and not being responsive to the Word and not receiving the promise. The Word, therefore, is seen also as demand. Failure to respond appears to mean that the promise is not experienced, as in the case of Moses who was not permitted to enter the land of milk and honey due to his failure to respond to the Word in the wilderness. Likewise, as the prophets struggled with the

disobedience of the people they discerned how punishment occurs as God's judgment against the rejection of the Word. The people called by God's Word are a people under contract. They are a covenant people and the terms of the agreement are established by God. If the people hear, they are blessed. C. H. Dodd writes, "Of his own free will God entered into a binding obligation toward Israel and called upon them to accept the reciprocal obligation on his terms, not theirs."[7] But suppose the people accept and then disobey the terms? The prophets bemoan the disobedience of the people, and assert that they will be disciplined and chastized in the events of history. Jeremiah prophesies (discerns) that Nebuchadnezzar, the king of Babylon, is Yahweh's servant to make an everlasting reproach.[8] Yet, Yahweh's anger (an anthropomorphism) is not forever. In fact, through his discipline his aim was to gain a hearing of his Word. As the people again respond and choose to be his people and to obey the terms of the covenant, another king becomes the agent to return the exiles to their homeland.[9] So the Word is heard as a call for the people to make a covenant of service or responsibility, to enter into

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[7]C. H. Dodd, "The Biblical Doctrine of the People of God," in Dow Kirkpatrick (ed.) *The Doctrine of The Church* (Nashville: Abingdon Press, 1964), p. 31.

[8]Jeremiah 25.9.

[9]Isaiah 41.2,3.

the joys of the Lord and to be participants in his promises. Throughout the Old Testament that Word is spoken.

The Word also is spoken to one called Mary. The late Carl Michalson remarked with profundity in one of his lectures that Jesus' mother was the only woman to get pregnant by hearing. There was auditory intercourse. At a propitious moment God spoke a Word to Mary and through her the Word ceased to be "mere word" and became personal word.[10] The New Testament differs from the Old in the incarnation of the Word. Furthermore, the New Testament regards the death and resurrection of Jesus the Christ as the saving event and looks back to the Old Testament and forward to the Kingdom of God (the ultimate fulfillment of his promise) to make sense of human existence on the basis of God's redeeming activity. The exodus from bondage is no longer confined to a particular people. In Jesus the Christ a new humanity has been inaugurated. God's creative activity through a personal Word, the incarnate Word, offers a "new land" to the whole world. Now a new people are called. A new Word is heard and makes a new claim just as there is a new promise. Those who respond, however, are still being responsive to the Word of God even though it is now expressed in a Person.

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[10]Emil Brunner, *The Christian Doctrine of the Church, Faith, and the Consummation* (Philadelphia: Westminster Press, 1962), p. 11.

This brief sketch of the history of the Word's presence among the Israelites and the Christians shows that there is both continuity and discontinuity. The continuity of the Word was claimed and at the same time the dis-continuity between spoken and personal Word was seen. Another element of continuity focuses on the obedience of the people and their election of responsibility to God's mission. The conviction of the early church was that the remnant of faith finally had dwindled to only one person and that for a time only he was obedient.[11] His obedience was the *via Dolarosa*. In the Cross a life lived on behalf of others was shown supremely. The Resurrection event recalled the disillusioned disciples and became a symbolic word proclaiming God's power over death and the awakening in them of the significance of the life of Jesus Christ. He was the beginning of a new people transcending national bounds and reaching to all the corners of the world. Hence, the calling of the twelve disciples symbolized the continuation of a people of the Lord who were responsive to the Word. As persons were obedient to God's Word proclaimed by the apostles on the basis of the Word made known to them in Jesus the Christ, a new covenant group, the church, was formed. Kee and Young put the matter better when they say "And the early church came into being in the faith that

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[11] *cf.* the comments of Dodd, *op. cit.*, p. 33.

through the death and resurrection of Jesus, and through the coming of the Spirit, God was finally calling his people together and fulfilling his promises to them."[12]

The other part of the polarity is the people. Probably, a signal feature from this perspective is the Christian anthropology regarding the act of faith. Although Emil Brunner acknowledges the bestowal of faith by God (along with classical orthodoxy), he incisively declares that the faith of the believer is not God inside the person believing for him but is an act by the person. Faith is man's response to the Word because the presence of the Spirit enables the believer really to know that Christ is for him.[13] Such knowledge establishes the basis of participation in the church. The church and faith are closely linked by Brunner because he sees the *ecclesia* and *pistis* as parts of the same picture. The Ekklesia is Brunner's word for the church and he writes that "the Ekklesia is founded by God's Word in Christ and the believing, worshipping answer of man."[14] God's Word calls the people and through their trust in the Word they obey. They accept the terms of the covenant and agree to participate. "The

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[12]Howard C. Kee and Franklin W. Young, *Understanding the New Testament* (Englewood Cliffs: Prentice-Hall, 1957), p. 437.

[13]Brunner, *op. cit.*, p. 12.

[14]*Ibid.*, p. 32.

Ekklesia is the form of life in which faith itself necessarily finds expression."[15]

Just as a distinction was made in the earlier discussion of God's Word which calls the people rather than God himself, so it is important to make a distinction and be more exact apropos the people who respond to God's claim. If one speaks of faith as an act of the believer whereby he "accepts the terms of the covenant and agrees to participate," an impression is created that faith is intellectual assent. The distinction then must be made which sees faith not as intellectual assent, but as a "leap of faith" as Soren Kierkegaard has described it. The calling by the Word is a high and perilous matter and mere mental gymnastics will not suffice. Or, put another way, the Word comes and makes both claim and promise. Only God can fulfill the promise. Only God, because he is God, is able to fill the unknown. The future is his, and the promise is future. Faith is the leap into the unknown as a risk that what the Word has spoken will be fulfilled. Abraham, for example, was to be the father of a great nation and yet he was asked to offer his only son as a sacrifice to God. Faith was not, then, an assent or agreement. It was a leap, a risk. The slaves of Egypt were to move all the way to Canaan. As they celebrated the special meal which

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[15]*Ibid.*, p. 20.

became the Passover, they were going forth not on the basis of mental calculations; in response to God's call they went forth in faith. Isaiah spoke the Word and asked the people to be prepared to return to their homeland by crossing the desert and leaving a land ruled by their conqueror. They had to believe to the depths of their beings that what God promised he was able to fulfill. Trusting God's Word that the promise will be fulfilled is essential. The believer risks and makes a "leap of faith" to go into the unknown to which he is called.

Probably one must say that the promise was not always fulfilled as it was seemingly stated. Abraham arrived in Canaan and due to the famine had to move on. He could not possess the land. He was a sojourner. Although Abraham possessed the land in faith, he came to possess the land in actuality only in his death and burial.[16] Or consider the slaves who wandered back and forth in the wilderness and did not move directly into the special land, the land promised to them. The letter to Hebrews traces the people of the Word and acknowledges that the promise was not fulfilled for them. Christians in the 20th century stand in the midst of history two thousand years later and still find a tension between promise and fulfillment. Yet, God's Word is spoken and people are asked to be responsive.

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[16]Nacpil, *op. cit.*, p. 15.

By trusting, and that not a purely human action but an opening of one's self through the presence of the Spirit, one risks and discovers by that leap that he is faithful.[17] So when a third of the 5,000 Methodists who were surveyed in 1959 described the church as a "society of those who have joined together in their quest for the religious life,"[18] they failed to make the distinction that specifies one of the basic dimensions of the nature of the church, *viz.*, the faithful response of believers whose action reflects a total giving of themselves because the Paraclete made the Christ event a personal encounter for them. Just as the Word of God particularizes the creative activity by which God is present in human history, so, also, faith concretizes the life style of the people who seek to be obedient to that Word.

The nature of the church has as its bases the *ecclesia* (the ones called out and assembled for a special task) and *pistis* (the obedient response of the people). These bases are the ground on which one must raise the issue of the purpose of the church. The church is not a voluntary association of people who are excited about a

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[17] *cf.* the comments of Thomas Oden, *op. cit.*, pp. 88-93, about faith and obedience.

[18] S. Paul Schilling, "The Church and Its Ministry," in Gerald H. Anderson (ed.) *Christian Missions in Theological Perspective* (Nashville: Abingdon Press, 1967), p. 17.

series of regular meetings to hear certain speakers. The church is a called assembly of people who seek to respond faithfully and who know that their calling by God is for a purpose. What is that purpose?

If the church is the people who are called by God's Word and who respond by faith, to what are the people called? To what is the church being faithful? Are they just to say a holy "Yes" to the Word and chant special formulas? What is the purpose of *missio Dei* to which the Word is calling people to obey? The answer in the broadest sense remains the same for church as it was for Israel. The difference between the two is to be found in methodology and in the specifics of the message. The people of God under the old covenant were to be a "light to the nations" and in the New Testament the disciples are to proclaim the "good news." In both cases, the salvation of the world is involved. The intentionality of creation or the *missio Dei* is that mankind, the peoples of the world, shall be aware of the transcendent power and live in loving relationship with God and with each other. H. R. Niebuhr and his collaborators in the Survey of Theological Education in the United States and Canada concluded that the ultimate purpose of the church which encompassed all other objectives was "the increase among men of the love of God and neighbor."[19]

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[19]Niebuhr, *op. cit.*, p. 31.

J. C. Hoekendijk, the Dutch theologian, writes in a similar spirit when he refers to the aim of evangelism as the establishment of the *shalom*.[20] Hoekendijk emphasizes that the *shalom* is more than personal salvation but is peace, integrity, community, harmony and justice. Both Israel and the church are chosen, called, to be a special messenger to the nations. God is reaching out to his world and seeking to lead mankind into that form of human existence that frees one from his own anxiety in order to be free to be sensitive to the needs of others and to respond as he is able. Jesus spoke the Old Testament words and the early church believed that these words embodied his *raison d'etre*:

> The Spirit of the Lord is upon me, because he has anointed me to preach good news to the poor. He has sent me to proclaim release to the captives and recovering of sight to the blind, to set at liberty those who are oppressed, to proclaim the acceptable year of the Lord.[21]

As the early church, *i.e.*, the eye-witnesses, observed their Lord in life and death and experienced him vindicated and victorious, they perceived that their calling was to share the good news that God loves the world and desires for all people a life that is abundant, filled with the Spirit of God, and thereby liberating persons to love God by serving their fellowmen.

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[20]J. C. Hoekendijk, *The Church Inside Out* (Philadelphia: Westminster Press, 1964), p. 21.

[21]Luke 4.18-19.

In the discussion of the bases of the church mention was made of Israel's being delivered from bondage in order to be priests of the most High. Israel is to serve Yahweh so that nations will come to the light and be saved. The methodology of the church differs from Israel in that the church does not sit and wait for the world to come (at least the thrust of the New Testament suggests that the church does not), but rather goes into all the world proclaiming the gospel, the good news. The specifics of the message also are different in that the church declares that Jesus has enabled mankind to see that a right relationship with God is possible by accepting his gracious gift of his unmerited love. Indeed, for the Christian community the fulfillment of the promise has come already although there is a sense in which the perfection of the promise in its completeness is yet to come. These differences are not to be minimized. The methodology and the specifics of the message distinguish the Christian community from that of Israel. The Son of God who was also truly the son of man proclaimed in word and deed that obedience to the Word leads one into the world to be present on behalf of God for a new humanity. The *missio Dei* is the humanization of man. The church is called to that mission and will remain his people only so long as it is faithful to that mission. The question then must be raised regarding the style or shape of the interaction between church and world.

2. THE WORLD-CHURCH INTERACTION

How is the saving work to be shared with the world? Since the time of Jesus the Christ his followers have sought to be in every corner of the world and to be his evangels. The shape of the message has been varied. In general, two particular shapes seem to summarize the many variations of world-church interaction. The most conspicuous shapes are (1) the salvation of souls and (2) the salvation of the structures of society. The former work concentrates on the individual and seeks to establish a new relationship between the person's soul and God. The vast missionary enterprise of the 19th and 20th centuries seems to have opted for this approach: *i.e.*, the salvation of souls seems to have been the major emphasis of the evangels. Yet, there has always been an emphasis which sought to bring the themes of righteousness, justice, love, and salvation into the structural aspects of human existence and to seek to foster changes so that the larger realms of personal existence would be affected as well. Partly, the salvation of society arose and exists today as a recognition that an individual's soul does not exist in vacuum (even though the person may be able to experience freedom in spite of social barriers as was the case with Viktor Frankl) but is lived within countless structures. But a more important evaluation of the church's focus on the

salvation of society is based on the theological perspective of the world and the relationship of Christ to the world.

H. Richard Niebuhr classically typed the perennial problem of the world-church interaction with his book *Christ and Culture*.[22] He organized the "series of answers" that have arisen across the centuries into five types. The two opposites, though they share similarities, are "Christ against culture" and the "Christ of Culture." In the former the exponents take the Christian way as a demand to be separate from culture and to oppose the world. They would take the either/or statement from Jesus' lips that a person cannot serve two masters and choose Christ. Since the world is evil, the Christian's only *modus operandi* is to pull away and to seek to keep himself holy, awaiting deliverance at death from the evil realm and the experience of future joy in the heavenly Kingdom. The individualistic salvation of souls is the strategy. The church becomes a military raiding party out to capture a few souls.[23] There is no intention to change the world. It isn't worth saving! These people are expected to be loyal to Christ only, and for such loyalty they are to be rewarded. But such a

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[22]H. Richard Niebuhr, *Christ and Culture* (New York: Harper & Row, 1951).

[23]*cf.* Nacpil, *op. cit.*, p. 95.

separatist position is a negative interaction with the world. "Celsus moves from an attack on Christianity to an appeal to believers to stop endangering a threatened empire by their withdrawal from the public tasks of defense and reconstruction."[24] The separatist posture is an interaction which belies the reality of life, *i.e.*, the continuation of human existence in spite of the negations of the radicals? To put the matter bluntly, how can these people marry and give birth to children? How can they earn a living? A sensitive person aware of God's sovereignty and cognizant of the corruption of society will persistently know that he cannot possibly withdraw from life, for he will as persistently know that God's call through his Word requires him to be present in the midst of the world's struggle. The exclusivistic approach is inadequate. In fact, it is to be criticized for its reliance upon an old cultural viewpoint to reject the work of Christians who are seeking to be relevant to the world.

The opposite view is dominated by the desire to harmonize the Christian way with culture. Jesus is blended with other folk heroes, all of whom lived to portray the best of life. For the "religion of humanity" the world is not to be rejected. Rather, one wants to be relevant to the times. The world is a beautiful place and when one

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[24]Niebuhr, *Christ and Culture*, p. 6.

reads the works and hears the teachings of special men he sees how much more beautiful life can be. The effort of these optimistic people to be aware of the world's situation and to seek to apply the good news to the points of need is to be congratulated. They do underscore what the first group implicitly denies, *viz.*, that Christ's Lordship is over all the earth and is not just reserved for the holy community. Certainly the liberals have contributed much to the process of change in society.[25] Yet, if this group is to be faulted, it would be because of their optimism--an optimism which vaulted to great heights in the late 1800's and the beginning of the 20th century as men sought to build the kingdom by their good works in society.

Between these two types are three others which struggle to handle the dialogue between Christ and culture. If a continuum were schematized for the five types and the "Christ against culture" were placed to the right and the "Christ of culture" positioned on the left, then the "Christ and culture in paradox" or the dualistic perspective represented by Luther would be standing with feet placed at opposite ends, seeking to be joyful in spite of the stretch and hoping always that the ordeal would soon be over. The two realms in which people are to live according to this typology produce a compartmentalized existence and

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[25] *Ibid.*, pp. 67f.

the resolution can only come with death. The "Christ above culture" would be slotted to left of center as it seeks to synthetize the two realms and in the process tends toward an absolutizing of what is only a relativity. But both approaches are true parts of the total picture. Along with the other two there are errors, as it seems there must always be as the church seeks to be obedient to the calling of the Word.

The conversionist type or "Christ the transformer of culture" position would be dynamically involved between the left and the right. It emphasized the kingship of Christ over culture and kept separate God's work and the work of men while at the same time noting that culture is distorted and corrupted but not totally evil. Niebuhr believes that this fifth position is the central tradition of the church.[26] Three theological convictions are essential to the conversionist motif. First, creation is a total process which is not replaced by the greatness of the Cross. God's creative activity suggests that the church can be positive about the world, not because it is a beautiful place as the liberal humanist would surmise, but because the work of God moves through all time: from creation through cross to consummation. The second conviction stresses the corrupted nature of the universe and

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[26]*Ibid.*, p. 190.

desires to be present to work with God for change. Here the conversionist differs from the exclusionist who sees the world after the fall as completely evil, a fetid swamp to be left alone. The third conviction concerns history. Time is not divided into three distinct bounds of before time, time in which people live, and after time. Unlike the exclusionists who long for the after-life and the eternal life with God in his perfect abode, the conversionist believes that the eschatological future has become an eschatological now, a pregnant presence. Whenever God is present, there is his eternity. Then is time not a chronological string of human occurrences but an eventful interaction between people and God. The conversionist does not wait for time to end but sees the transformation of culture as all things are lifted to a new level that humanizes man and glorifies God.

So how does the Niebuhrian typology of the dialogue between Christ and culture enable one to make sense of the two shapes of ministry? What may be said of the interaction between world and church? The salvation of souls seems to be chosen by those who isolate Christ's lordship to the sphere of the Kingdom, reject the world because of its evil, divide time into segments, and elevate the future. The church is a haven and holy place which is somehow free of sin, while the world is an evil place to be disciplined by a law that darkens the gracious, loving act of God in

Christ Jesus. There is really no alternative for the Christians who espouse the "Christ against culture" but to shape their ministry along the solitary lines of the soul. The other four types all deal with culture (or world) with the more effective style being the conversionist or transforming type of interaction. There are bound to be attempts to change structures when the world is viewed as corrupt, but not as totally evil. The church which is conscious of the basic goodness of creation and the ongoing creativity of God in the midst of history will seek to be concerned with the conditions in which people live, and seek to discover where God is working in the world and what the church ought to be doing in society to be obedient to the Word. The salvation of society will be seen as very much a part of the church's ministry. Hopefully, as Brunner asserts, the church will be known through its service and not its worship.[27] Of course, one may quickly add that service is a form of worship. God is glorified when love among men is increased because of the awareness that God also loves his people and gave his son for their sakes. The saving, concerned interaction of the church in the world seeking to transform life now into a loving experience means that both pastoral and prophetic postures will be evidenced. There will be times when the church will be

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[27]Brunner, *op. cit.*, p. 32.

politically interested in the world on the basis that the church is asked to be the guardian of the state. If the latter fulfills her duties, the church need not speak against her. "So long as the state acts to maintain justice and order, the church as such may not engage in direct political action against it."[28] There will be times when the church's primary target will be to eradicate social evils. When it is determined that the state is not maintaining justice and order, the church must "raise its voice." Harold DeWolf says the church

> would not show true compassion to minister to those who are bruised and broken by injustice or war and yet not to raise a hand in defense of the multitudes who are being prepared for fresh injuries...Rather the church must incessantly raise its voice in prophetic warning against the social evils in all the institutions of the day. The church must not try to be a state or an economic order, but remaining in its own role as conserver and voice of the spiritual life within, it must continually speak to the state and the economic order. In all its judgments it must avoid even the appearance of being one organization competing for power and prestige among other organizations. Its peculiar power lies not in self-seeking but in searching for truth and justice and peace for all, in the spirit of Jesus Christ. For this, too, is part of being "first" by being "slave of all."[29]

Although Bonhoeffer would be willing to go further than DeWolf and take action against the state rather than just

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[28]John D. Godsey, *The Theology of Dietrich Bonhoeffer* (Philadelphia: Westminster Press, 1960), p. 110 quoting Bonhoeffer.

[29]L. Harold DeWolf, *A Theology of the Living Church* (New York: Harper & Bros., 1960), p. 326.

voice the objections, the two join in the kind of world-church interaction which has been described as the salvation of society. There will be those who would object that the church is meddling in politics and that the church has forsaken her spiritual task. Yet, the "spiritual" is the transcendent, integrative power of God, active in the midst of human events. The church must continue to act in the world to seek "truth and justice and peace for all." The church must act on the basis that God is the sovereign Lord of all history and that Christ's redemptive activity is on behalf of persons and structures. And the church must act with the awareness that even its perceptions are relative, formulated out of the present dialogue with the world, and, therefore, be willing to repent of her failure to continue to seek out the places of God's activity in the world. Is one of those places the health care crisis in this nation? That is the subject of the third and final section of this chapter.

3. THE INTERFACE OF CHURCH AND HEALTH

The present patterns of the church as it has sought to be related to the matters of health has been to build and support church-related hospitals, to provide specially trained clergymen to be hospital chaplains to visit the sick as a member of the healing team (if the doctors invited them!), and to encourage health professionals to see

their work as a Christian vocation. These approaches are needed. They contribute to the care of the sick and enhance the work of the personnel in the health facilities. But their limitations are obvious in that only individuals are served, and even they are served within a framework determined solely by the physicians. Such is the situation at present, a present with a rather brief history. Clearly a few changes are in order, particularly with respect to the clergy's place in the healing team and the need for church-related hospitals to move again to the cutting edge of health care as they did in the 19th century when they were established in this nation to provide assistance to those not getting care. This is quite justifiable from a theological perspective.

The Word is the creative activity of God present in the drama of history. The Word makes a claim of faithful obedience and offers a promise of blessing. The church is the church as it obeys the Word and lives faithfully in loving service. The purpose of the church is to be present in the world so that there is an increase among men of the love of God and each other. The task is the salvation of the world. As such, the church is the continuation of God's redemptive servanthood in Christ Jesus. What does such a conclusion suggest for the interface of the church and the health care systems? What complementary strategies might the church adopt?

The specific strategies can be considered only after a sociological analysis indicates some aspects of the needs of the world. But first some general comments are in order. The church needs to be involved in health care because the problems already cited militate against the well-being of society. Society is threatened because some people are not getting any care due to the shortage and inequitable distribution of personnel, the excessive costs, and the uneven distribution of facilities. Racial and sexual discrimination in the health field and professional dominance are underlying causes. These matters are not benign, needing only minor treatment and possessing a good prognosis. The magnitude of the problem is intertwined with other elements, *e.g.*, increasing population and demand, better stewardship of all resources and particularly the financial ones, and the equal possibility of abundant life for all. As long as society is ill, the church must be involved both to treat the ailment and to seek to prevent further dis-ease. Such a grave social problem calls the church to be present in "saving" activity. The church must not only raise questions, but it must seek to be involved in the health care field in such a way that through the interface God's saving activity is experienced in social change that increases among men the love of God and each other. The church is not just meddling. The church's primary concern is with the conversion of the world, and

that explicitly means improving the structures of human existence. Health care is one. To know more specifically what strategies the church should design as it is obedient to the Word and involved in health care a sociological analysis must be undertaken. Such an analysis is the thrust of the next chapter.

CHAPTER III

A SOCIOLOGICAL ANALYSIS OF OPEN SYSTEMS

The church knows of her obligation to be in the world and of the content of the *missio Dei*. But the question remains as to the where, the when, and the how of her mission, and that requires a knowing sensitivity to the social situation. This includes an understanding of the nature of those structures or systems which comprise our culture and of the interdependence of persons and systems. For the purpose of this discussion a particular system theory has been selected, *viz.*, the open systems model, and it will be presented in some detail.[1] Then attention will be given to the phenomenon of innovation: the phases of the change process, client systems and change agents, obstacles and aids, and strategies. These two aspects will then be tied together for the purpose of identifying the sociological dimension necessary to the final chapter which has to do with the church's strategy.

1. THE OPEN SYSTEMS MODEL OF SOCIETY

Human life is a constant interface of systems and persons in various situations. The interdependence and

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[1]Daniel Katz and Robert L. Kahn, *The Social Psychology of Organizations* (New York: Wiley, 1966).

daily interaction in relationships suggest that those respondents to society and its problems and conditions who seek to understand events must make a conscious effort to be cognizant of the mutuality of structures and of the existence of persons involved in those systems. Katz and Kahn have suggested that the failure of the Behaviorists, Freudians, and Field Theorists can be traced to their preoccupation with the individual.[2] They ask, instead, for a recognition of man's organizational and institutional involvement: the waking hours a person spends in these structures.

Although psychologists have tended to focus on the individual's growth, the theories underlying their work have made use of interpersonal dynamics, *e.g.*, Erikson's model of personal development (trust, autonomy, etc.)[3] and Sullivan's shared expectations.[4] Values develop from shared expectations, a process which begins in the home first with the mother and then with other family members and which continues throughout the adult life as persons participate in various groups, organizations, and increasingly with other cultures. Finally, the movements on

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[2]*Ibid.*, p. 2.

[3]Erik H. Erikson, *Childhood and Society* (New York: Norton, 1950).

[4]Harry S. Sullivan, *Collected Works* (New York: Norton, 1964).

the contemporary scene for family therapy[5] and therapy which involves other interpersonal relationships with the identified patient,[6] as well as the growth and use of the National Training Laboratories and the Departments of Human Relations in universities, indicate an awareness among psychologists and sociologists of the larger units or systems of human existence.

The inadequacy of individualism arises out of the fact that persons do not live in a vacuum. To seek to enhance personal existence without taking the social structures into account is as ridiculous as it would be to seek to sail across the open seas without a compass. It is difficult to conceive of a time when a purely individualistic model would have sufficed for those in the helping professions; in these times, the thought is impossible. The proliferation of information on a world scale in the electronic age is best attested by the comparison of the news coverage and information flow of the two presidential assassinations, Lincoln's and Kennedy's. Consider, also, the "war" in southeast Asia which is the first to be "fought" in our living rooms as families watch the newscasts and special reports. Many elements militate against an

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[5]Virginia M. Satir, *Conjoint Family Therapy* (Palo Alto: Science and Behavior Books, 1964).

[6]E. Mansell Pattison, *Clinical Psychiatry and Religion* (Boston: Little, Brown, 1969).

individualistic perspective of life like the mobility of population, rapid change, and technology. The fast freeways, jet travel, and the affluent society account for the frequent weekend forays into the world of leisure with the concomitant increase of spheres of social interaction. Individualism is superseded by a systems approach with the multiplicity of personal contact, the increasing institutionalization of life, and the mounting pluralism of culture, as well as the homogenization of civilization. Even if there were no forms of mass media, if families were isolated by considerable distance from each other, and if they were self-sustaining, one still would need to accept the systemic nature of society because the minimal social system of husband and wife, or parent and child, would exist.

To speak of a system is to point to the repetitive patterns of actions between units A and B and possibly other units (the units may be persons, informal groups, organizations, nations, etc.). One observes that the output of A is part or all of the input of B, and the input of B is necessary for the existence or functioning of B. The next step in the exchange is the response of B to A's output and the response of A to B's output. The reciprocal response to the energy or information exchange of outputs is termed <u>action</u>. The repetition of a series of actions becomes a pattern and that repetitive pattern is a system.

System is, therefore, distinguished from a stimulus-response model, *e.g.*, Pavlov's dogs, unless observers realize that the response of the dogs had an effect on the Russian scientist. There must be an exchange or flow for a system to exist. Another way to describe a system is to point to the emphasis on the "principles of mutual influence in a fluid field of forces."[7]

Before the characteristics of social systems are presented the differences between biological and social systems need to be sketched. An initial and signal difference between biological and social systems is the relative "physical boundedness that social structures lack."[8] We might assume (as we view the buildings) that a social system has physical boundedness but that is not so. "A social system is a structuring of events or happenings rather than of physical parts and it therefore has no structure apart from its functioning."[9] A second key distinction between the two lies in the greater importance and greater complexity of maintenance inputs for the social systems. Energy which is taken into the system to sustain it is termed maintenance input. Production input is that energy which is imported for the sake of yielding an outcome. Certainly, a physical body requires energy to

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[7]Katz and Kahn, *op. cit.*, p. 30.

[8]*Ibid.*

[9]*Ibid.*, p. 31.

maintain itself whether it produces or not. The stress, however, is laid on the greater amount of energy needed to keep the people attracted to the system, to motivate them to fulfill their roles as prescribed by the system, and to be open to the variety of information flow, yet committed to their identity within the system. Another feature of social organizations is the contrived nature of the structures. Men fabricate organizations from, and according to, their social mileau with their peculiar *Weltanschaung*.

Since the focus of this work is the church and health (social phenomena), the systemic concept must be specified further, *i.e.*, social rather than general systems. General systems theory "has been in the direction of finding analogies and isomorphisms between chemomechanical and biological systems."[10] Berrien believes that general systems theory provides a bridge between the natural and the social sciences. This dissertation takes for granted the work of general system theorists and the commonalities in all systems and accepts social systems theory as a special segment of general systems. The purpose of social systems is "to understand human organizations, to describe what is essential in their form, aspects,

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[10]F. Kenneth Berrien, *General and Social Systems* (New Brunswick: Rutgers University Press, 1968), p. 8.

and function,"[11] the phenomena exhibited in the repetitive behavioral acts created by persons. Monane defines social systems in this way:

> Social systems are the recurrent patterns of action of people and culture. They may involve one or many persons, together with cultural phenomena such as words, ideas, artifacts, rules, beliefs, and emotions.[12]

A husband and wife represent a social system just as much as General Motors or Luxembourg. Where the sending and receiving of energy/information occurs in the interplay of persons, a social system exists.[13] To comprehend the interplay, a social systems theory is adopted for the sociological analysis.

The open systems model of social organization calls attention to the degree of openness between a system and the environment. It is difficult to conceive of a system that is closed or impervious to the reactions of others to the output of one's system. This suggests that there is some degree of openness, and so the social psychologists propose the open system theory which was developed by von Bertalanffy.

Various characteristics of the open system model are important. Nine points delineate the commonality of

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[11]Katz and Kahn, *op. cit.*, p. 14.

[12]Joseph H. Monane, *A Sociology of Human Systems* (New York: Appleton-Century-Crofts, 1967).

[13]*Ibid.*, pp. 1f.

all open systems.[14] Although biological organisms are open systems and are used here for illustrative purposes, the emphasis is on the social systems. First, all open systems import energy. The metabolic process of biological organisms requires oxygen and glucose converted from foods. Social organizations import energy in different forms from the environment with which they interact. Second, systems share the characteristic of through-put. The foods mentioned above which are converted into glucose underscore the through-put or productive aspect, and the through-put continues as body energy is converted into action. Organizations process ideas, items, and individuals. Third, the action is the output. Something is produced. Ford produces a car. A seminary trains ministerial candidates. The Rand Corporation creates ideas. Katz and Kahn call this theoretical model "an energic input-output system."[15]

To understand an organization as "an energic input-output system" is to know, also, that the "energic return from the output reactivates the system."[16] Systems then are repetitive patterns of action or cycles of events. This is a fourth and crucial characteristic of social systems. Biological units may be identified by their bodies and this defines their physical boundedness; but systems of

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[14]Katz and Kahn, *op. cit.*, pp. 19-26.

[15]*Ibid.*, p. 16. [16]*Ibid.*

a social nature are structured around events which repeat themselves in patterns. If a person wishes to know the type of organization, then he must follow the events through the input, through-put, and output cycle. When the input is not adequate to provide energy for maintenance and production, then the organism's demise occurs. "To survive, open systems must move to arrest the entropic process."[17] Negative entropy is the fifth point, and again we note a difference between biological and social systems. We have yet to successfully delay a creature's death. Organizations, however, are able to import more energy than they need to survive and thus store energy and develop the capacity (or subsystem which expends energy to find ways) to keep the system alive. Thereby, the concept of negative entropy for social systems is determined.

The process of communication or the flow of information is the sixth characteristic. As the output interacts with the environment, feedback occurs. The feedback comes to the system as information input which in turn sets in motion the filtering task of the organization. The filtering task is called the coding process. Such a phenomenon may be seen most graphically and caricatured by the elderly gentleman who turns off his hearing aid when his wife protests too much. Yet, a pressing need is to

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[17] *Ibid.*, p. 21.

perceive the feedback as corrective and beneficial. To change the analogy, an air traffic controller scans the radar scope and informs the pilot of a necessary course correction. Failure to respond is (in all probability) to court death. This is particularly true when the pilot cannot use visual flight operations. It is equally important to make the point that screening or coding of feedback must occur. If a person, group, or even a nation is to make sense of the plethora of sensory data, a filtration subsystem must exist. The sense-making or coding is a way of putting the material into usable forms that the system can comprehend. There is a danger in this characteristic. When a system's coding process becomes inflexible and selects only that information which it wants to hear, then it has insulated itself from the real world, and the necessary course corrections will not be perceived. The archaic qualities of that system then become increasingly visible and, likewise, other systems in the environment watch in horror as undue energy is expended by the senile system to publicize its virtues and to proclaim its authenticity.

The seventh element of open systems seems to suggest that the speculation of organizational senility is unwarranted. All systems seek to maintain themselves in a steady state and a dynamic homeostasis.[18] That character which

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[18] *Ibid.*

identifies the system is protected, as we noted above, by the importation of more energy than is needed so that stability and balance are achieved. Likewise, a growth or expansion of the system occurs. As the system seeks to protect itself in the interface with other systems of the environment, it will incorporate the other within itself or seek to outgain and conqueror it. Even when a system seeks to enhance its product, to improve the quality, expansion occurs. Some experience transpires from the interaction of the two systems and that experience is cumulative in the sense that a new level of operation is reached for the systems. Lewin cited this as a quasi-stationary equilibrium and "stated that in the adjustive process the old level is not returned to in all cases."[19]

Differentiation and equifinality are the last two of the nine characteristics.[20] In the former, the tendency of organizations to progress from a general or broad basis to a more specific purpose is noted, and the latter feature indicates that organizations can reach a final goal by several routes. Through the adaptive process alternate routes may be chosen to reach the original goal.

From the previous discussion of open systems the dependence of organizations on the surrounding mileau is heavily buttressed, and the critical thesis of this chapter

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[19] *Ibid.*

[20] *Ibid.*

is a corollary of that reciprocal interface of systems and environment. Individuals cannot be dealt with or adequately known unless their roles in the various systems of which they are participants are understood, and systems are not isolated units moving through a vacuous space. The open system model affords the social analyst a macrocosmic and a microcosmic arena. One may focus finely on the roles of the participants, the psychological facets of personal existence, or the focus can be widened to the social facets just cited. Seemingly then, a realistic scheme for the comprehension of life exists which offers an appropriate basis for responding to the problems and conditions of society.

To function as an open system analyst requires the knowledge and use of certain conceptual tools. An understanding of norms and values sets the stage for the concept of roles in the social organization. Five typical subsystems should be known (see below, p. 82), as well as the principle of maximization, power, authority, leadership, change, and the principles of communication. This will provide a basis for assessing the need for change in health care and the church, which leads to the discussion of the models of innovation.

Values are fundamental and the basic stratum from which organizations operate. Norms are less abstract and operate on a more conscious level but stem from the basic

stratum of values.[21] Norms serve the gate-keeping function on the boundary of the organization, and they serve, also, in the determination of the roles which are developed in the system. Another way to describe the norm is to think of the overt conduct or behavior of the members of the group and note that their private-personal norms are modified by the expectations of the group with which they are identified. The company's norms, rooted in the ideological underpinnings, channel the workers, offer a certain givenness, out of which the positions or roles are developed.

The most distinguishing feature of a social organization which provides the uniqueness or identity of the system is that of the roles played by its members. "Parsons (1951) and Merton (1957) consider [roles] essential to understanding social action and social structure."[22] If one wishes to grasp the significance of an organization, he does not look at the building. He goes inside the physical structure and observes the roles, *i.e.*, the nodal events or the repeated activities of the workers. These organizational acts or positions comprise the role(s) to be performed. Each person performs several roles. He may be husband, father, factory worker, union member, churchman, Scout leader, etc. In each of these "offices" there are certain norms or shared expectations shaped by the various

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[21] *Ibid.*, p. 152. [22] *Ibid.*, p. 171.

systems and their values. To the extent that one is motivated to be a member of each of the systems, he is bound to accept the norms and values which prescribe his attitudes and views, although the person may interact with the role and reshape it because of his uniqueness. The role is the specified function which reflects the person's organizational behavior. The system "assigns" its roles, and the member in reciprocal fashion "takes" a role. The dynamic interplay of organization and person suggests such matters as influence, compliance, and resistance.

There is much more that could be said of norms, values, and roles and an equally brief treatment must be given to the five basic subsystems. These brief treatments of the topics are set forth, in part, as efforts to familiarize the reader with the facets of the sociological analysis, but, more importantly, they are the vital elements in the church's perception of the world in which its mission is performed and in grasping the essentials of an institutional innovative process of church *viz. a viz.* the health care systems. The subsystems are maintenance, production, support, adaptation, and management.[23] Maintenance is committed to the internal functioning of the organization. The subsystem acts as a stabilizer and formalizes the seventh characteristic mentioned previously,

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[23] *Ibid.*

viz., a steady state and dynamic homeostasis, its stability and balance. The more integrated the system the more productive it is. The various supervisory roles illustrate this. The technical or productive subsystem concretizes the through-put phase. Here the materials of the input are transformed into the various products that the organization wishes to market. There are various subsystems on the edge or boundary of the organization which support the productive capacity. Sales, marketing, and procurement are examples. However, the subsystem with greater involvement in the system-environment interaction is the adaptive one. Planning, research, and development units function to alert the system to changes in the environment and to help the other subsystems to make the best use of those changes so that the organizational life is enhanced. The fifth subsystem is the managerial structure. The function here is to make those decisions which affect all levels of the organization's existence. It cuts across all the other units and often is forced to make various compromises to keep the organization on course. Katz and Kahn state that in more primitive organizations the maintenance and adaptive subsystems are constituent parts of management. As the organization grows, subsystems are formed to perform the multiplying and increasingly specific tasks. The two authors recognize, also, that Parsons uses only a three-part scheme: technical (includes maintenance,

production, support, and adaptation), managerial, and institutional.[24] The latter is designated for decision-making apropos the external relations, whereas managerial focuses on internal matters. One example offered was the school board as the "institutional subsystem" and the superintendent as the "managerial subsystem."

Maximization is the next conceptual tool and is the term which describes the system's persistent thrusting. The forward thrust must contend with internal problems and the constant tendency to expand to overcome difficulties within the system rather than to prune or eliminate any elements. Yet, its dependence on the environment forces the system to be cognizant of how much expansion it can afford and to forego possible expansion in the interest of negative entropy. Maximization accounts for the expenditure of energy to foster favorable relations with other systems. It reminds one of the psychological principle of the will to power, the *elan vital*, the thrust to be. It suggests that a social organization is like a vital organism, and raises the possibility that its tenacity may be in direct proportion to its perception of vulnerability and finitude.

But who decides what will maximize the organization? The use of power and authority is another factor to be considered. For the effective working of the

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[24] *Ibid.*, p. 96.

organization, individual acts must be kept to a minimum. There needs to be formal or informal incentives and punishments to foster adherence to the prescribed roles of the system. One's imagination can picture the small, *i.e.*, primitive, organization, with little structure to maintain role behavior. However, the increasing complexity of the organization behooves the system to develop such structures as will promote the level of reliability required. Three specific reasons for the need of authority are that (1) social organizations are composed of people and not machines, which implies the urge toward personal autonomy, (2) across the life of the organization replacements of personnel are necessary and a training task is demanded to help the new recruit fit into the system, and (3) the presence of change demands organizational response and response means that the basic philosophy is continuously in flux and new goals must be formulated. Hence, there is the need for authority or the legitimation of influence. Without authority there will be chaos. Of course, one may speak of autocratic authority and democratic authority. The former invests all the power in the top echelons, whereas the latter acknowledges a broader base for decision-making. The experience of the National Training Laboratories has proven, also, that when the "maintenance" of the group is dealt with, the task or production of the group is increased. Proper group maintenance occurs in a

democratically-styled process. Of course, each type of authority-structure possesses its own advantages and disadvantages, with greater organizational cohesiveness and flexibility associated with the democratic type. "There is evidence, however, that the broad sharing of leadership functions contributes to organizational effectiveness under almost all circumstances."[25]

An aspect of authority and power is the key element of leadership. Who speaks of organizational life without reflecting on the leadership? Just as certain factors point to the need of authority, so others justify the need for leadership. Leadership is needed throughout the system since (1) a system is not perfect or is incomplete, (2) environmental conditions are changing, (3) there is a dynamic quality to the internal nature of the system, and (4) organizations are human.[26] The function of leadership is to use, interpolate, and originate structures out of a systemic perspective. When present structures are routinely administered and when present structures are interpreted and applied to meet immediate problems, leadership has occurred at a lower level in "use" and "interpolation." When policy has been designed, the origination of structures has been the task of leadership. Usually, leadership exists whenever an organization has been influenced in a relevant

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[25] *Ibid.*, p. 335. [26] *Ibid.*

manner.[27] One may have difficulty grasping the separation of a discussion of management and leadership until he sees that leadership occurs throughout the system, but management is reserved for that subsystem which oversees the total organization.

Obviously, there is a close relationship between management and leadership. An equally close relationship exists between management/leadership and communication, although the phenomenon occurs outside leadership functions. Communication is the "exchange of information and the transmission of meaning."[28] The execution of routine matters and the interpretation of policy to handle problems imply that the communication process is happening. An important matter of communication in the organizational context revolves around the factors of time and systemic need. In recent times, pressure has been exerted in some circles (and expressed in society) to get persons to open up and communicate freely. The assumption is that oral catharsis contributes to personal health in proportion to the frequency of verbalization. In a systems approach it is important to realize that a poorly timed flow of information may impede or freeze the components involved. The information flow may yield certain conflicts, problems, and flaws which, if dealt with as the person in a particular role

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[27] *Ibid.*

[28] *Ibid.*

(or actually because the role was abandoned) saw fit, might impair the system. What is being suggested is the need to understand the system and wisely control the flow of information. This may suggest the need to establish some mechanism to facilitate timely dialogue with persons outside regular channels.

Two other factors in communication which are relevant to the sociological analysis are coding and overloading. Since coding was discussed earlier, only the latter factor will be considered now. This term implies that more information is coming into, or going through, the system than can be handled. Since no ideal or static environment exists, *i.e.*, the world is constantly in flux and in an undulating flight pattern, the exchange or communication flow is systemic-environmental, and the intrasystemic units can be termed only as optimal rather than ideal. Overloading is the term reserved for those occasions when the optimal conditions have been surpassed which then leads either to dysfunctional or adaptive responses. Miller has presented several categories of organizational response to overloading but, basically, they can be broadly categorized under the two headings of adaptive-dysfunctional.[29]

The last conceptual tool which must be considered

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[29]J. G. Miller, "Information Input, Overload, and Psychopathology," *American Journal of Psychiatry*, CXVI (1960), 695-704, in Katz and Kahn, *op. cit.*, p. 231.

is that of change. Since a later section concentrates in detail on the models of innovation, it is necessary only to note that change is always present internally and externally to the system. Earlier mention was made of personnel replacements. This is change. The origination of policy by management is change. Feedback from an organization's output may require modifications and that is change. Because of its dependence on the environment for the completion of its energic cycle and because of its human components, an organization is constantly redefining its *raison d'etre* and its structures and roles. However, such a process may be more or less unconscious. To assume that some sort of mechanism automatically adjusts the organization to the intra- and inter-systemic changes is to act from an outdated theory. Contemporary social scientists accept the need for planned change. They are equally aware that change does not occur through a reorientation of individuals who work in the organization, but the components of the organization must be consciously changed. Since social organizations operate out of a set of values and norms with specified roles which are enforced by the system, clearly, to try to change individuals and then ask them to re-enter the system which has not been concurrently altered is to ask them to swim against a very strong current.

A systemic perspective has been developed to urge the response of innovation at the system level rather than

the individualistic one. The validity of the open system model with its nine characteristics has also been sketched to further justify the systems approach. One may conclude from this discussion that a system is dependent on others for energy. A lack of sufficient energy for both production and adaptation through research, planning, and development will allow entropy to occur. An effort is always made to maintain stability and a dynamic homeostasis, but with a concern for maximization: the intent of the organization is to live, grow, and expand. Add to these elements the possibility of equifinality or reaching the goal by divergent paths and one begins to grasp the phenomenon of innovation as a benign quality rather than a lethal weapon. Actually, failure to change indicts the system as unresponsive.

2. MODELS OF INNOVATION

One assumption made here is that change is not only a desirable but a necessary condition for systemic growth and that deliberate or planned efforts ought to be skillfully applied. A second assumption may be put this way: "Change of organizational characteristics is regarded as inherently difficult to bring off because it means changing so much, and, of course, this is correct."[30] There is a

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[30]Katz and Kahn, *op. cit.*, p. 427.

cost involved to "bring off" the necessary and desired change. Some of the essential aspects of planned change are the following: first, three phenomena of innovation: phases, the client system, and the change-agent system; second, the obstacles and aids, or the change forces and resistance forces; and the strategies for change.

When considering the phases of innovation, one must bear in mind that the different schemes articulated by different scientists probably reflect different stages of the change process.[31] Also, they reflect alternate processes or approaches of innovation. If a problem-solving approach is being considered, then the focus is on the needs of the client system and the strategy hinges on the best method to facilitate the recognition of the problem and its definition. Suppose, however, that a research development and diffusion model exists. Then the emphasis underscores the new idea and strategies are shaped to gain maximal adoption of it. The social-interaction perspective sees the total society or supersystem as a network of communicating units and efforts are devised to enhance the flow of information, to overcome the barriers. Each scheme or "school" operates under certain assumptions and strategizes accordingly, although the intention is not to suggest that there are no

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[31]Ronald G. Havelock, *et. al.*, *Planning for Innovation* (Ann Arbor: Institute for Social Research, University of Michigan, 1971).

similarities. There are, and the overlapping occurs in the description of the phases of innovation.

Lippett, Watson, and Westley[32] altered Lewin's three-step system and suggested seven steps. Both, however, operate from a problem-solving perspective. Lippett and his colleagues added some features and expanded the middle step of Lewin's scheme. First, they call for the awareness of need, and then the helping relationship is defined. Lewin spoke only of "unfreezing," realizing the need for change and the willingness to give up the former patterns. Lewin's middle step is "moving," which means that those activities are begun which will implement the change. Three steps are cited by Lippett, Watson, and Westley: (1) identification and clarification of the problem, (2) alternatives and goals are surveyed, and (3) efforts to bring about the change are attempted.[33] Under Lewin's third phase of "freezing" the other authors placed two steps, *viz.*, stabilizing the change and ending the client-agent relationship. Freezing was the term to mark the "establishment and firm rooting of the new behavior in the life of the group."[34] The brevity of the Lewinian model certainly

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[32]Ronald Lippett, Jeanne Watson, and Bruce Westley, *The Dynamics of Planned Change* (New York: Harcourt, Brace, 1958), p. 123.

[33]*Ibid.*

[34]*Ibid.*

describes what is going to happen in a given change situation. The advantage to the seven steps of Lippett's model is the clearer delineation of the process. Perhaps in that more detailed procedure one is more alert to the warning of Havelock, *et. al.*[35] In their discussion of change, they caution against the omission of the stage of diagnosis. Aware of the pressure for change, they caution against rushing into the action phase to solve the immediate problems. Unless the problem is carefully identified and clarified and the alternate courses of action pondered and the various goals scrutinized, one is in no position to take any action. In Lewin's three phases the process of change is succinctly described, but the addition of other phases does clarify the process and enhance its successful resolution.

Out of the framework of the social interaction model a five-step process is presented by Havelock and his colleagues from the Institute of Social Research and, more particularly, the Center for Research on Utilization of Scientific Knowledge. In their efforts to research the educational, medical, and agricultural fields for dissemination and utilization of knowledge models, they learned of Rogers' scheme. A rural sociologist, Rogers speaks of

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[35]Havelock, *op. cit.*, p. 10.34.

awareness, interest, evaluation, trial, and adoption.[36] The assumption is that the appropriate change and method may be known but the way to get it across is the difficulty. The innovator's strategy is geared to capturing the attention of the client system and then motivating it to seek more information. In the evaluation phase, the client system is manipulated to process the innovation mentally, to make a dry-run through the brain, and consider its potential for present and future needs. Then a trial period is initiated, and a successful outcome leads to adoption, or "the continued use of the innovation in the future."[37] Rejection may occur at any phase of the process.

Whether one is inclined to prefer one or the other of the two schools is not really the question. The innovative strategy is dependent on the needs of the situation. In one system the problem is not known and the client does not know what innovation or solution might be adopted; then the problem-solving model is needed. If, however, the system's problem is known and the solution or innovation exists, the five phases of the social interaction model might be chosen. But imagine a situation in which the solution is not known and a researcher is aware of certain issues and societal problems. Then a different

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[36] *Ibid.*, p. 10.30.

[37] *Ibid.*, p. 10.39.

model arises. It is a four-step process of research, development, diffusion, and adoption.[38] Perhaps it is sensed that the user or client system is a passive partner in the research, development, and diffusion school. The perception is correct. In fact, it is accurate to surmise that the innovation may not be chosen by a system. The critical phase is the one of diffusion. The purpose then is to "create widespread awareness of the invention among practitioners..."[39] To be specific, consider the drug salesman or detail man of the pharmaceutical house. If he uses the proper message at the right time and is the proper person and covers over a wide area, then one might assume that the adoption of the innovation will occur.[40]

As the health care crisis is considered, which of the three schools might be utilized in different situations? Take the case of the President of the United States and his administrative personnel assigned the health portfolio who wish to see the adoption of the Health Maintenance Organization (HMO). Either the R,D&D model could be used or the S-I model might be employed. The problem-solving model does not seem appropriate because the basic effort seems to be to get the particular innovation adopted. But if the work begins with the consumer of health care, or

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[38] *Ibid.*, p. 10.41.

[39] *Ibid.*

[40] *Ibid.*

with the providers of health care, and the specific innovation is not considered until the nature of the problem is clearly identified and defined, then the particular model of problem-solving ought to be used.

A pastoral counselor does put considerable emphasis on the P-S approach, because of his focus on the needs of the client. Yet, he is mindful of the distinct advantage which exists with the models for therapy which have been tested by others and are available once the problem is recognized. But what are the client's needs? Who is the client? Since the thrust of the sociological analysis is on the system, it seems wiser to think of the client system. Certain problems may be hypothesized. Because of the nature of the social organization previously described, both internal and external problems will be expected. The innovator (*i.e.*, change agent or facilitator) could look for power, communication, and energy problems internally. The contrived nature, as well as the human composition, suggest that as the organization grows new centers of power will develop and will be in contention with the other centers of power. Or the flow of communication may seem meaningless, arbitrary, or non-existent. The flow may be in only one direction. Communication relates, also, to the mobilization of energy. Hidden "forces" drain off energy which might be used in production. Another way to look at the matter is to picture the need for a technical and a

socio-psychological fit.[41] A productive system has a technical level of roles, but equally present is a network of persons who have needs of their own other than the performance of the organizational task or institutional role. To the degree that the socio-psychological level is fulfilled the technical level will be fulfilled. When the former level is not satisfactory, energy will not be properly mobilized; then communication must occur if that energy is to flow properly again for the good of the system. Communication is concerned, further, with the system's perception and possible distortion of that reality which comes from the environment. These are four points that a change agent might expect to encounter in a client system.

The first task of the change system is to determine the nature of the problem. Second, an assessment of the client system is in order, the better to grasp the readiness and motivation for change and the resources available in the client system. The next step is directed at the change system as it considers its skills and capabilities to help the client. Then the target is selected. Where is the primary locus of the pain? And what strategy needs to be chosen to facilitate the eradication of the problem or the adoption of the innovation? The continuous assignment

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[41]Katz and Kahn, *op. cit.*, p. 433.

which cuts across these five tasks is the establishment of rapport with the client system.

Conscious of the above five tasks the change system must recognize also the forces present for change and those that resist; and just as rapport cuts across the change system's tasks, so motivation lies across the client system's obstacles and aids for change. At first glance, pain may seem to be the basic motivation in favor of change, and it might be entered on the credit side of the ledger. Yet, pain may also immobilize. Pain may bring resistance, but if it is sufficient and persists, the maximization principle and negative entropy will marshall positive forces to seek change. There are other factors which seem more clearly to be obstacles or aids.

Those forces which foster change might be labeled broadly as beginning and emerging, *i.e.*, some factors may initially aid the change process and others may be more important once the change is occurring. Internal and external pressures which build up lead to the awareness of the need. The major aids for change once the innovation is underway are:

1. to stay with the project now that it has begun
2. the perception that the system is making the change and not the agent
3. the desire to satisfy the agent's expectations
4. the rate of change is not too fast

One may picture the leadership of the system making an investment in the change and then questioning its value but finally determining to remain with it since it has begun already. Nancy Milio poignantly describes the aids to change, as well as the obstacles.[42] One of her primary discoveries was the need for the people to be the planners and decision-makers. "The storefront that did not burn," symbolizes the awareness of the people that they were making the change and the change was not imposed on them. Certainly, the rapport of the change agent and the desire of the people to continue with the change process out of their desire to satisfy her are implicit also in the book.

Likewise, the book captures the struggle between the interdependent subsystems which nearly scuttled the project before it was really started. There were times when the goals were rejected and had to be redesigned. Other times the agent of change was the target of the resistance. Other systems in relationship to the identified system disliked the development and were obstacles. Probably the one obstacle that was weakest and therefore did not sabotage the project was the group who asked, "who wants to change?" The question verbalizes the client's perception of threat. Havelock spoke of the perceived

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[42]Nancy Milio, *9226 Kercheval* (Ann Arbor: University of Michigan Press, 1970).

threat to the system. Threat may be felt as inadequacy or as preference for the familiar and fear of the new. The desire for a medical facility or neighborhood clinic and a day-care center in the Detroit ghetto outweighed the sense that they were inadequate for the task. They certainly preferred the new to the old. They wanted the change. That factor, combined with the aids for change, facilitated the completion of the project. Success may not occur always when the aids surpass the obstacles, but the strategies for change must take them into consideration. In fact, it is appropriate to add that the wise strategy would be an aid, whereas poor strategy would be a hindrance to the process of innovation.

The final segment of the second part concerns the basic elements for developing strategy. These points are not specific methodologies or techniques, although part of the strategy of the change system would be to know and be skilled in them. As one considers the phases of innovation, one must be cognizant of the need to coordinate strategies and phases. What would work best to unfreeze the system? What will help the system to stabilize the change? What enhances the movement of the system? Another point an innovator must keep in mind is the source of the problem. If the matter is caused by internal strain, then the tactics will differ from a situation in which the problem involves a change of input. The target or locus of

pain further determines the course of action.

Another way to look at strategy is to consider some basic rules of change. When change is collaborative, it works best. Earlier this factor was cited as an aid to change along with the need for a system to see the change as its own doing. In reality, this is a collaborative effort. Techniques will be chosen to assure this development. Also, when change is seen as experimental, it will be received more readily. Finally, strategy is conscious of the elements of timeliness and the initiator of the change. If an air tragedy has just startled the area, then an atmosphere of readiness prevails for new regulations or the installation of different control devices. Havelock, *et al.*, recorded the research of Brickell in the New York State public schools after the launching of the first Soviet "Sputnik." "The rate of innovation...had more than doubled in the fifteen months following the launching...in October of 1957."[43] Other researchers spoke of "peak development of interest and goodwill," "appropriateness," and the moment of "crisis."[44] The timing of an innovation is critical. The question of the initiator raises the validity of external change systems *viz. a viz.* the system's own personnel. The earlier descriptions of social systems and the

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[43]Havelock, *op. cit.*, p. 10.77.

[44]*Ibid.*, pp. 10.79f.

characteristics of open systems would lead one to think that system identity, those features which make the organization unique and foster loyalty, urges the innovator to develop such strategy as will lead the client system to believe that the change is coming from within. Another facet of the initiator points to the matter of "temporary systems."[45] Workshops and seminars are considered temporary systems. But who sponsors these events is crucial. The coding aspect of communication may lead the client system to reject the innovation if they perceive the change system to be alien. However, studies reported by Havelock, *et al.*, suggest rather convincingly that the initiator of the change is not as crucial as the manner in which it is carried out.[46] The manner is the strategy, and the effectiveness of the process clearly depends on the wise consideration of those basic elements of strategy and the techniques which fit the strategy. The next chapter offers some strategies for the church's involvement in the health care field. At this juncture it seems appropriate to indicate how the sociological analysis applies to the development of those strategies of the church.

Earlier mention was made of the where, the when, and the how of the church's mission which necessitates a

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[45] *Ibid.*, p. 10.82.

[46] *Ibid.*, pp. 10.84f.

sociological analysis as well as the theological one. In the course of the chapter the intention was to provide material to help answer the where, when, and how. The most crucial aim of the material was to justify the contention that the helping professions or systems of which the church is one need to operate from an open systems perspective. To that end the discussion of the values, norms, and roles of the social organization showed how the broad, ideological underpinnings are specified in the roles and how supervision utilizes rewards and punishments to enforce adherence to the system. The acceptance by persons of the organizational roles implies that the system is to be protected rather than the individual. The apparent sacrifice of the individual does not mean that there is no concern for the person. The socio-psychological fit with the technical level may be remembered and may suggest the need for personal concern by the system. The point, however, is one of priority and that priority rests first with the system and then with the individual. It is understood, of course, that the system will be enhanced only when individuals sense personal fulfillment in their roles. If the thesis that systems predominate is granted, then the church's strategy as innovator must take into consideration the necessity for changing the health delivery system and not just appealing to individual health professionals to alter their work. The church cannot do that because then

she asks the impossible. There may be some alternate patterns of health care to which those persons may be directed, but such a strategy will not effect long-term results unless it is part of a larger strategy to provide input for the primary organization of health professions, *viz.*, the American Medical Association. The "where" of the church's mission must be the system of the health professionals and, more specifically, the organization of the physicians. In view of the developing medical-industrial complex, one senses that the "where" must be enlarged to the super-system. However, the dominance of the profession, cited in the first chapter, indicates that when the doctors agree to a change then other units of the super-system will follow.

The "when" focuses on the timeliness of the change and the sensed motivation of the client system. The change system or agency, in this case the church, must know the situation in the environment, the readiness of the client system based on the resources and motivation, and the capabilities of the change system. When these elements are meshed, then the time exists for the change.

The "how" raises the question of models of innovation, phases of change, awareness of obstacles and aids and the appropriate strategies. How will the church be able to influence the information flow or input into the health care system? What strategies must be developed to foster rapport and to enhance positive response by the system and

to prevent overloading of the communication process and the coding mechanism? The sociological analysis clearly indicates that on the basis of equifinality and maximization the social system will seek a new balance or homeostasis because it is an energic input-output system. The system will deal with the different input and that will require the reformulation of the philosophy or ideology of the system which in turn will alter the norms or the more consciously perceived *raison d'etre*. As the norms change, the roles will be changed and that means that the repetitive patterns of action or cycles of events which characterize social organizations will be recast. The end result will be new patterns of health care delivery. With an awareness of the where, the when, and the how as it applies to the health care crisis what strategy will the church adopt? The next chapter will seek to answer that question.

CHAPTER IV

NEW STRATEGIES FOR THE CHURCH'S INVOLVEMENT IN HEALTH CARE

In the preceding chapters it was suggested that the church is part of the present crisis in health care insofar as the approaches it has taken to date focus only on the individual and the treatment of disease, following a medical science model which has defined health as the absence of dis-ease. The critical problems in the health field behoove the church to consider new strategies. Such involvement in the problems of society is properly within the purview of the church's ministry because the Word of God calls persons into a covenant relationship with Him within the context of history, and claims them for a mission of service to the world. This relationship between the community and God continues as long as the people faithfully keep their covenant with Him to work for the increase among men of the love of God and neighbor.

Since the health care structures (it is no monolithic giant even though it is characterized by some as the medical-industrial complex) militate against the well-being of persons in the world, there can be no "increase among men of the love of God and each other" as long as there is lack of personal health care for some, abuse of

environmental conditions to erode the health of all, financial burdens which paralyze others (this matter cuts in two directions, those who are treated and accumulate an enormous debt and those who are out of work because they are sick and can get no care), discrimination in the training as health professionals based on minority status and sex, and a domineering of the field by physicians.

But to have any impact on this problem it will be necessary for the church to alter its involvement in the health field to reflect the interface of two institutions rather than attempt to influence health professionals one-by-one. To appeal to individual health professionals to alter their patterns of health care would be as effective as if one were to put a band-aid on a crushed jaw when a tracheotomy was required. Clearly, the involvement of health professionals in certain strategies of churches would be appropriate if the purpose of the strategy is to develop new structures for health care.[1] If such strategies are to succeed, the client system must accept the need for change. The change agency (the church) must know the nature of the problem(s) and the peculiarities of the client system's input, through-put, and output subsystems, and must know its own limitations and capabilities. A

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[1]See the discussion below pertaining to the initiation of new patterns of health care by church-related hospitals.

central motif of the different strategies, then, is for the church to alert society to the need for change in the patterns of health care delivery and the places where innovations are occurring. This requires that the church know what needs to be done and what is being done. Hopefully, in all cases the church will seek to be constructive and enable society to put health into perspective so that a total, positive view of health is the goal rather than the medical science one.

All this points to the need for new strategies if the church is to be responsive to the world in the midst of the health care crisis. The specific strategies suggested here give attention to two levels, the national and the local. There may be occasions when a regional level also might need to be operative; such moments might occur as the national level sought to initiate some action or program in certain areas for specific reasons pertinent to that region or as the local areas expanded to facilitate their work. The assumption implicit in these proposals is that the churches will seek to share together across denominational lines and will form "clusters" of churches where such action would enhance the mission of God, *i.e.*, the salvation of the world. An ecumenical approach is needed so the world may experience a combined effort for health. More importantly, the church, with its responsibility to "increase among men the love of God and each other" needs

to reflect that task within its own life style and thus say a personalized Word that the church is committed to the well-being of the total community.

On the national level existing boards and agencies of the church are favorably positioned and presently organized to guide a multifaceted approach to alert people, stimulate thought, communicate information, and support innovative models and policies. For example, there is a Board of Health and Welfare Ministries within the United Methodist Church which could utilize the publications of the church to describe the problems existent within the health care field. They could work with similar agencies of other denominations and traditions to compile analyses of national health legislation pending before Congress. Or they might discover someone in the world who has performed the analysis needed and then give it their support through public endorsement and/or publication resources. Certainly, these Boards could work together to share information about various projects across the nation that seem to be using creative ways to meet the crisis. But the point is to use the favorable position and the resources these Boards have (and the opportunities to utilize their leadership) to support the pioneer projects in health care that tackle the problems already cited. The need is for the churches at the national level to consciously place health care in a priority position and to marshall the

efforts of the church to facilitate change in the health care system.

Another strategy would call for the agencies within the churches to provide health plans for the workers in the churches which would contract only with those groups who are making a serious effort to deal with the crisis. Specifically, contracts could be negotiated with prepaid plans and with organizations where the doctors functioned as a group. Or as the Health Maintenance Organizations (HMO) or similar community-based, community-operated prepaid models of health care delivery become more prevalent, contracts could be negotiated with these systems.

Also, through the American Protestant Hospital Association or the Catholic Hospital Association the initiative could be taken to cooperate with and foster efforts for comprehensive health planning. The member hospitals could become a national vanguard for innovative patterns of health care delivery, *e.g.*, the inclusion of consumers in the policy-making of the hospital. This would mean that bankers, prominent citizens, etc., who usually comprise the board of directors in a hospital would not be loosely termed "consumers" to satisfy a legal technicality. Rather, persons representing a broad spectrum of the community would be involved in the decision-making.[2] Some areas for

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[2]The writer is aware that several persons involved

consumer decision-making might include the hours of operation (why are lab facilities and x-ray units basically open from eight to five Monday through Friday?), the admission procedures, or the development of out-patient services or clinics. There is no suggestion that consumers will tell a doctor how to practice the art of healing as some suggest when they seek to besmirch the idea. Finally, the member hospitals might be the ones to initiate community action in concert with the churches to establish a Health Maintenance Organization. In Valencia, California, the Lutheran Hospital Society hired a director and received federal funds to build a hospital and establish an HMO with the hospital as the focus.

On a national level and in cooperation with the Association for Clinical Pastoral Education could come new thrusts in the clinical training of clergymen in hospital

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in the health care field as professionals disagree with him because they believe that most consumers are not qualified to serve on the decision-making bodies. On the other hand, there are such health professionals as Lester Breslow, M.D.,* and others in the public health field who urgently call for consumer participation. The important question in the formation of Health Maintenance Organizations revolves around the extent of consumer participation. This question is the battlefield *royale* in this decade.

*Dr. Breslow is chairman of the Department of Preventive and Community Medicine, School of Medicine, UCLA; a member of the "Committee of 100" who prepared the national health insurance material now in Congress called the "Kennedy Plan"; and an advocate of reform in the American health system.

facilities. In addition to the development of skill in the pastoral care of the sick, the training ought to be concerned with administration, policy, and community participation. Possibly there are already some clinical supervisors who are including the institutional concerns within the scope of their training. But there is need to give additional emphasis to the art of ministering to the institution as well as to the sick. This need recognizes the fact that as structures are cared for the conditions of the persons within the system are improved.

In view of the nature of the crisis and the probable legislative action that will be taken by the federal government, the National Council of the Churches of Christ would be well advised to hire a full-time person to serve in Washington, to set up a "situation room," and to work with those persons who are writing legislation. Hiring a "legislative technician" was one of the proposals adopted by the denominational health representatives when they met in Chicago in January 1971 under the auspices of the Urban Training Center.

There exists already an Urban Training Center for Christian Mission.[3] UTC, however, is not adequately

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[3]This agency is located in Chicago and is supported by several denominations as diverse as the Southern Baptist Convention, the Church of the Nazarene, and the Episcopal Church. It was organized about 1962 in an effort to enable the church to be more effective in the inner city.

financed by the denominations. Secular foundations have carried the largest bulk of the funding. If it possessed adequate resources, it would be able to research the health situation and to coordinate the training of laity and clergy. The accumulated research of UTC could be disseminated through the national church bodies mentioned earlier. The research would include an analysis of national health legislation, strategizing for new models of health care based on a redefinition of health, and compiling information on experiments in process across the nation. The training would enable the churches to be effective change agencies. The Urban Training Center's total program is not being endorsed at this point but is being supported for its potential development by the denominations to serve as a national resource. Much of what has been described for UTC is already being attempted on a small scale through their Issue Forums and the Caucus of Denominational Health Representatives as well as their research efforts. The point here is to emphasize a greater potential and the need for better funding.

The local level is divided into three sections: a congregation, a parish which brings together three congregations, and an interfaith organization of health professionals and concerned consumers who purpose to facilitate innovations within the health care field.

In a local United Methodist congregation there is

an office designated for the health task. A similar position may exist in other denominations. In previous years the office was created to serve as a liaison between church-related homes and the churches. Its role is still rather limited and needs to be expanded in view of the health care crisis. Conceivably, the officer and/or committee ought to join with the educational and social concerns areas to sponsor some of the events listed below. The first way to expand its role is to broaden its scope and look at the health needs of the community. As their horizon is extended, they will discover the implicit demand to know more about the problems, underlying causes, and emergent issues of the crisis. They will want to know more of new developments and begin to seek for information. At this point, the national level can be feeding material to the local level through the church publications. As the church ferrets out information, the presence of other groups engaged in changing the health system may become evident. These religious and secular oriented groups will need to be screened and may prove to be solid partners in the midst of a very complex situation. The more the health and welfare officer and committee are absorbed in the health care crisis the more they will be stimulated to share their findings with the congregation. In the process of its search for knowledge and developments the group must continue to ask the question of the relationship of the

church with its avowed purpose to the health care system.

In the course of a year, the health committee or even a dedicated single officeholder may

1. write brief articles for the church newsletter which present facts and which evoke thought and action;

2. announce mass media opportunities through the church bulletin;

3. sponsor seminars or other study sessions;

4. develop a speaker's list for women's, men's, and youth groups;

5. initiate action through the administrative board to offer church facilities for health care work:

   a. office space for a mentally retarded association, etc.,

   b. space for a situation room to chart the changing scene of personal and/or environmental health care,

   c. day care facilities for hospital employees which is geared to early education and not just baby-sitting and which functions around the clock,

   d. provide voluntary services and facilities for out-of-town families who are visiting a parent or child and who need baby-sitting;

6. cooperate with other church and/or community groups whose goals seek to enhance the health system and through methods that are consistent with the basis and purpose of the church; and

7. work with the pastor to see that he is alerted to the crisis and has an opportunity for an orientation to the problems and emergent issues.

Where two or more congregations have joined to form a parish, the health officers and committees may consolidate their plans and energies into a health task force. In

the Hollywood United Methodist Parish which was formed in July 1971, a health task force is being formed to deepen the understanding of the membership about the health care crisis and to participate in the community with other groups who are seeking to facilitate innovation within the health system, particularly Joint Health Venture. The health task force of the parish will be composed of four persons from each congregation and one of the ministerial staff who will serve as the chairman. These persons will be chosen on a basis that maximizes serious study and is open to consider the need for change within the health system. The most advantageous composition would be a physician from each congregation who is joined by another health professional and two consumers. The consumers would have to be very strong persons and not ones to be awed by the doctor. It would be necessary for the physician and the other health professional to be sensitive to the traditional dominance of the profession which doctors have exercised and other professionals have obediently honored.

The health task force would seek to implement that which the health officer and/or committee of the local congregation would do if there were no parish and no task force. The group would meet with Joint Health Venture, and it would work with the Senior Citizens Task Force which is related to the new parish and a church-related retirement home. A community out-reach program for the elderly is

being developed and two common points of interest are the dietary deficiencies of the elderly and the great need for health care. Possibly the educational TV plans of Joint Health Venture could be expanded to meet the special needs of the elderly.

Joint Health Venture of Hollywood began a couple of years ago as an emphasis of a Join Hands group. Join Hands arose when some women felt the seriousness of the racial bigotry in the United States following the assassination of Martin Luther King and "joined hands" to see what could be done in different areas of society to uproot the evil. But in that Hollywood community, where one of the largest hospital complexes exists at the corner of Sunset and Vermont, the perceived need for action was determined to be health. The selection of health as the target was probably due to the leadership of Dorothy Wagner, a registered nurse, and her husband who were acutely aware of the problems in the health field.[4]

The projects of Joint Health Venture include the assistance and support of one of its members to develop a day care center for hospital employees, the formation of an allied health professional training center as a pilot project which occurred through the joint interaction of the

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[4]John Wagner is the West Coast representative of the National Council of the Churches of Christ and an urban sociologist as well as a Lutheran clergyman.

Hospital Council of Southern California and Joint Health Venture,[5] and a six-weeks seminar on the health care crisis which attracted thirty persons from the entire Los Angeles basin and offered the resources of the best leadership in the metropolitan area. The seminar has become a model for a project of the Church Women United.

Two other projects are in process. A convocation for clergy to orient them to the crisis in health and to the developments that are taking shape in certain organizations concerned with the crisis will be offered in early October. The other project, mentioned in connection with the elderly, is the development of programs for television to educate persons for greater personal responsibility in health and to train community or neighborhood health workers. Cable TV is being considered but there are problems.

The one area which Joint Health Venture has not consciously entered, and which it must, is the development of community participation in the decision-making bodies of health facilities. The critics of consumer participation may be partially accurate when they denounce the idea. Some orientation of consumers to be better participants

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[5]This pilot project, which still needs to be funded, seeks to utilize one facility to train the allied health professionals needed by the hospitals in the Hollywood area which thereby frees the training staff in each of the hospitals to serve the health facilities in other ways. The target here is the undoing of duplication to increase the supply of personnel.

would be advantageous. Joint Health Venture could include the program within its educational tasks. Such a training program would equip consumers to be more effective participants in comprehensive health planning agencies. But the need is to train persons who will be able to work with health professionals to develop new patterns of health care delivery. These new patterns would emphasize the prevention of disease and would utilize the physician's unique skills for acute illness and injury as a part of a total health maintenance picture. Hospitals would be used for serious episodic care, and out-patient clinics would be used for early disease detection and periodic examinations and innoculations. To function in a decision-making body the consumer would need training. A group such as Joint Health Venture would be the proper agency to offer such a program.

The course for consumers would entail twelve weeks and would follow an initial six weeks of an overview of the major areas of health care. The advanced course would delve more deeply into the areas surveyed in the introductory course. The latter course would consider the following areas with one session each for

1. Manpower (nurses, physicians, and allied health professionals) - noting the kinds of careers and the nature of their work
2. Institutions (acute, convalescent, free clinics, special treatment centers, half-way houses, etc.)

3. Finances (third party, fee-for-service, prepaid or capitation, and government)

4. County Services (health departments, mental health, environmental control, etc.)

5. Consumers (community-based groups, patient advocates, etc.)

6. Consumers - what can they do to strengthen their participation in the community?

The advanced course would look in depth at each area and spend two sessions with each topic. Such an educational program would enable the consumers to be more effective when they are part of the decision-making process.

Both the national and the local levels must work toward the increased participation of the total community where the concern is not pathology but health. The church with its gospel is particularly suited to the role of speaking to the health system and for the task of training and organizing the community to participate in the non-therapeutic decisions of health care. It is possible that the American Medical Association will accuse the church of being a communist front when it seeks to work in the health field. Precisely, then, is the church best fitted for the task. To respond with faith to the call of God's Word is to acknowledge that there is only one God. The church can make no special claim to righteousness and perfection as the "Christ against culture" groups may wish to do. The church can make a witness to the Word of God which asserts that the reckonings of people take on the

characteristics of their time. Persons articulate positions indicative of their historical moments. To accept the "One beyond the many" as the absolute, man needs to recognize that he makes gods of his historical fragments and often takes courses contrary to radical monotheism. The church declares that the pressing of one's energies into a defense of one's historically conceived courses is idolatrous. The church also announces that God through his sovereignty continues to work in the lives of people and to effect a radical reconstruction of their beliefs and values. Such a transformation is a revolutionary process which occurs as we personally apprehend the significance of Jesus Christ, *viz.*, the disclosure of the One beyond many to be for the many. The apprehension takes place in history over and over again, not being perfected in a static sense in one's lifetime,[6] and is the moment of revelation which is enabled by divine grace. To know one's self and others in relation to God is to be more completely human and to be in community as God's people. The church as the people of God is called in the 70's to be pastoral and prophetic in an interface with the health care systems. The church is called to facilitate new patterns of health care delivery. The church is called to help the community

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[6]H. Richard Niebuhr, *The Meaning of Revelation* (New York: Macmillan, 1941), p. 182.

to participate more fully in the shaping of innovations in the health system.

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